State of Maryland / Department of Health and Mental Hygiene 3850 I Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** December 3, 2004 2:15 A. Rita Hagel Vore /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M XXF Days Hours Yrs. 357-09-6905 Director 89 Feb. 8, 1915 Illinois Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ent: If item 27 Is marked other than "natural", or Items 23a or 28e-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ust be natified at 1 Yes XXNo Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21228 709 Maiden Choice Lane Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) f Health and Mental Hygiene. item 27 is marked other than "natural", or Items other traumatic event, the Medical Experiment. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: If Yes, Give Year or Dates: 3XXWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 4 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Josephine Michael Eugene Anthony Hagel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Vore (Son) 5492 Mystic Court: Columbia, Maryland 21044-1800 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State o = 0 XX Burial 2 Cremation 3 ☐RemovaLfrom State Dec. Department of Importent: If eny injury or ▼□Donation 5 □ Other (Specify) ark Cemetery 2004 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home Loudon Park Cemetery Sonature of Funeral Service License 3620 Wilkens Avenue Baltimore, Maryland Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each ling. Immediate Cause (Final disease or condition resulting in death) Physician een /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Vear Day 4 Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 200 No 20/No certificate 1 TYes To the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Thomicide within 24 hours a 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 30. Name and addless person who completed cause of death (Item 23a) (Type, Print) tins ville 5 75 Med (hoy 31. Date filed (Month 32. Registrar's Signature State 2004 Registrar

		-	For State Registrar	State of Ma	aryland / Dep	ertificate of l		nental Hyg	iene 	38502
	Physicia	an	Decedent's Name (First, Middle, Last Joseph	S.	Vaskis			2. Date of Death Month Dec. 3	Day Yea	3. Time of Death  4:15a <sup>M</sup>
>	/Medic Examin		4a. Facility Name (If not institution, give			Silve	Location of Death			tgomery
	Funeral Director		130-14-1020	<b>*</b>	e (In yrs. last birthda) 78 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6/22/1	926 N	Birthplace (State or Foreign Country) Iewark, N.J.
	raryland show	or	Usual Residence of Decedent           10a. State         10b. County           MD         Montgo	mery	10c. City, Town or Silve	ocation er Sprine	a 			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
:	death with the Maryland ms 23a or 28e-f show	i Director	10e. Street and Number 3142 Gracefiel	d Road		10f. Zip Code	904	1	0g. Citizen of What	
		by Funeral	11. Maritaf Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13 No 1945 – 1946	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispa <i>n</i> ic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		merican Indian, /hite, etc. /hite
Maryland 21215-0036	filed within 72 hours after Hygiene. other than "netural", or Ite ant, the Medical Exar, it a	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) Coflege (1-4or	(Given iife	edent's Usual Occup ye kind of work done DO NOT use retired	during most of wor ii)	king	16b. Kind of Busine	sss/Industry forcement
land 2	2 should be filed and Mental Hygis is marked other eumatic event, it	To Be Co	17. Father's Name (First, Middle, Last) Stanley Vaskis					ne (First, Middle, M ert		
	T		19a. Informant's Name/Relationship (7 Maureen V. Heim			iling Address (Street				nd 20776
Baltimore,	Pages 1 and nent of Healt int: If item 2 ury or other		20a. Method of Disposition 1			position (Name of ematory or other place of the control of the con			20c. Location - City North A	or Town, State
Baltil	pernit. Page Department of Importent: If any injury or once.		21. Signal of Truneral Service Ucer	See			umbia B	lvd.Sil	ver Spr	ICE,P.A. ing,Md20910
760, 1/2	Physician and /Medical Examiner properties of physician and physician site prints of the prints of the physician and physician and physician and physician and physician and physician are properties.	ical Examiner	23a. Part 1. Enter the disease, or companies, or heart failure. List only of the state of the st	a. Colo	d the death. Do not eine.  OVESICUL: a a consequence of): a a consequence of): s a consequence of):			or respiratory arm	est,	Approximate Interval Between Onset and Death Weeks
O. Box 68	that the death certificate hed by the attending phy delached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	B Ectopic pregnance Control of the c	y		23d. Date of Month	delivery Day Year
Division of Vital Records, P.O.	requires been sign should be	Completed by Ph	Part II. Other significant conditions of congestive he obstructive particles and congestive care.	eart fai. oulmonar	lure, chi y diseas	ronic e, ather			es 2 No 3 and a sy prior death	
Vital	sicien: certifica rector, p	Be	25. Was case referred to medical examiner?	Hoenital:	ient 2 ☐ ER/Outpa	Ott		ath (Check only or		Specify)
on of	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Inj (Month, D.	ury 28b. Time	of 28c. Inju	ry at		ow injury occurred	specify .
Divisi	el or Atter s after dea al Director ad in by the	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of II	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Town		or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical (	29a. Certifier 1  Certifying Ph (Check only one) 1  Medical Exam	nysician: To the bes niner: On the basis and manners	t of my knowledge, di of examination and/o stated.	eath occurred at the training of the state o	me, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manne late and place, and	or as stated. due to the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier	tu MD		29c. Licen: D 2 4	se number 1035	2	29d. Date signed (M	
	15		30. Name and address of person who Eugenio S. Mach		death (Item 23a) (Ty)		oad Sil	ver Spr	ing,Md 2	20904
	St Regist	ate rar	31. Date filed (Month, Day, Year)	N/	trar's Signature	for Some	E.			

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ORIGINAL

State of Maryland / Department of Health and Mental Hygien [ ] 38503 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** December a 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Bay 7. Age (In yrs. last birthday) Jaman tan HIMOVE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
12–12–49 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2□ F Months 219-52-5745 54 Director N.Y. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expurit net must be inclined at once. 10d Inside City Limits 1X Yes 2 □ No Director Md. NA Baltimore 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 1427 E. Lafayette Avenue 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: À Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 3 Car Salesman yrs Antwerpen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Haskell Wallacr, Sr. Beatrice ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline L. Wallace Wife 1427 E. Lafayette Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State

44 □ Donation 5 □ Other (Specify) King Mem. Pk. 12-7-04 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East I orde 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dan Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DNOUVS /Medical Examiner Datic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physician and as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical cate has been signed by the attending I page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate has 1 ☐ Yes 2MNo 2□ No 1□ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 11 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe December 2,2004 5601 Loch Roven Blvd Baltmore, MD 21239 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD bia Koman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 06 Registrar

		1	For State Registrar	State of	Maryland		artment of		Mental Hygi	ene 2004	38504
			. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	pay 2004	3. Time of Death
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	Examin	ęr <sup>4</sup>	a. Facility Name (If not institution, 633 N. Aisquit			12 д		or Locetion of Deat	n	NA	
	Funeral			. Sex	7. Age (In yrs. la		If Under 1 Year Months Day	r If Under 24 Hrs	8. Date of Birth	9 Bir	thplace (State or Foreign ountry)
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	5 = N L		Norman Wiggins	Brotl				ew Rd., Ba	altimore,		
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Balti	permit. Pag Department Importent; I eny injury o		21. Signature of Funeral Service L	icensee W on	رتوس		2. Name and Add			imore, Md. E. North A	
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/	n		30. Name and address of person	who completed cau	se of death (Item	1 23a) (Typ	e, Print)	E. EAR	RST E	BALTO. N	1004 1021202
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ı	Physici		1. Decedent's Name (First, Middle, Last)	d wheatle	u Se	2. Date of Death Month D	ay Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give s Saint Joseph I	treet and number)	4b. City, Town, or Location of Deat		c. County of Death	18:124
	Funeral			7. Age (In yrs last birt	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthp	1 M O M e
	Director		Usual Residence of Decedent		rs.	3-8-do	MAK	KAND
	death with the Maryland ms 23a or 28a-f ehow	tor	10a. State 10b. County  PALTIN	10c. City, Town	TOUSAN		1	0d. Inside City Limits 1 ☐ Yes 2 No
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Dallimo	permit. Pag Department Important: Imy injury c		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lice are		22. Name and Address of Facility 73	6-04 BA	MITIMONE.	LAD SIGHT
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מט	sician: The law certificate has b irector, page 2 sh	Completed				24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
V 11.0	sician: certific lirector,	o Be (	25. Was case referred to medical examiner?	ospital: 1 Manations 200 50/00	Othor	th (Check only one)		
5	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	H   1	27. Manner of Death 1 Natural 5 ☐ Pending	28a. ate of Injury 28b. T.	patient 3 BOA 4 Intersting in	ome 5 Aesidence 28d. Describe how inju		)
	or Atten after deal Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street al City or Town, State	nd Number or Rural e)	Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Examinone)	ician: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an	and manner as sta d place, and due to	ited. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifile	1/4/1/	29c. License number	29d. Da	ite signed (Month, D	ay, Year)
	,7		30. Name and address of person who cor	npleted cause of death (Item 23a) (	Type, Print)	10	4012	
	10		31. Date filed (Month, Day, Year)	32. Begistrars Signature	: ;!VE ; TOWSON MARY!	AND 2120		
	Sta Registr		DEC 0 6 2004	Sz. adjistral S Signature	Sparks			

		For State Registrar		State of Ma	aryland /	Departme Certifica			d Menta	al Hygier	20114	38	506
Phys		1. Decedent's Name (	First, Middle, Last)	DILLIA	145					ite of Death	Day Year	O Time	of Death
Funera Directo	al	4a. Facility Name (If n 251 5. Social Security Num 23 V - 3 6 -	S, 300 ober 6. Sei 9412 10	eldin	St.	birthday) If Uno Yrs.	or 1 Year	ocation of De	Irs. 8. Da	ite of Birth onth, Day, Yei	4c. County of Déa	1	
vith the Marylend or 28a-f show	ctor	Usual Residence of D  10a. State 1	ocedent Ob. County	f		own or Location	re		***			10d. Inside	City Limits
death v me 23e	Funeral Director	10é. Street and Numb 25] 11. Marital Status	s. Bo	12. Was Decedent I Armed Forces?	St.	10f.	Zip Code 212 sedent of His	224 panic Origin? , Mexican, Pu	(Specify Ye	es or No-	14. Race - Ame Black, Whit	A.  prican Indian,	
21215-0036 ad within 72 hours effer rigione. or then "neturel; or ite	र्व					Sa. Decedent's U	vork done du	Specify:	vorkina	16b.	Specify: B	lack	
O pas	Be Completed	Elementary/Second	ary (0-12)	College (1-4or 5	+)	life. DO NO1	use retired)	Aio	1	Middle, Maid	en Sumame)	Sysi	tem
laryla 2 should end Men 1s marks	ToB	19a. Informant's Nam	a/Relationship (Ty	po, Print) Fuller de	wahty 15	9b. Mailing Addre	ss (Street ar	Acla nd Number or	Rural Route	e Number, Cit	or Town, State,	_	
Ore, of Heei		20a. Method of Dispose 1 M Burial 2 0 4 Donation 5	Cremation 3 □R	emoval from State	20b. Place	of Disposition (A	other place)	)	Date	-	Location - City or	Z/Z Z Town, State	2.4
Baltim permit. Pag Depertment Importent:	Suce	21. Signature of Fune		Dand	are	28 Name	em. and Address		10-20 uglas	s Fun	eval 50 to. Md.	212,	-
Physicia		23a. Pert1. Enter the shock, or heart f Immediate Cause (Findisease or condition resulting in death)	ailure. List only or	cations that caused in each lin	the death. De e. HEI	o not enter the m	ode of dying,	such as card	iac or respi	ratory arrest,		Approxim Interval B Onset and	etween
cete be executed EXAMPLE of the buriel-trensit the buriel-trensit		Sequentially list condif any, leading to imm cause. Enter Underfo Cause (Disease or in that initiated events resulting in death) Las	- C	Due to (or as a Due to (or as a		e of):	YE	LOH	A.				
O. Box 6 ne death certific the ettending p	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent print the past 12 mg 1 □ Yes 2 ☑ 1 □ Yes 1 ☑ Yes	onths?	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea	th 3□Ectopic 5□ Other (					23d. Date of del Month	ivery Day	Year
Cords, P. ( w requires that the table of the signed by should be detected.)	ed by Ph	Part II. Other significa	int conditions con	itributing to death bu	it not resulting	in the underlying	cause given	in Part I.	23		use contribute to	the cause of	
									-	a. Was an autopsy performed?	24b. Were au prior to death?	topsy finding completion of 2 No	s available cause of
of Vital F Physician: Th this certificate	To Be	25. Was case referred examiner?  1 Yes 2 No.  27. Manyfer of Death	1	ospital: 1 ☐ Inpatie		Outpatient 3 🗆 [	Other:	4 🗆 Nursing	Home 5	Residence	6 ☐Other (Spec	cify)	
Jing After	Certification;	1 Natural 2 Accident	5 Pending investigation 6 Could not be determined	(Month, Day	Year)	Injury M		es 2 No	28f. Loc	cation (Street by or Town, Sta	and Number or Ru	ral Route Nu	mber,
pite ours ours filled	cal Ce	29a. Certifier 1	Certifying Phys	sician: To the best of	f my knowled	ge, death occurre	d at the time	, date and pla	ce, and due	e to the cause	(s) and manner as	stated.	(e)
To the Hos within 24 h To the Fur	Medical	29b. Signature and titl		and manner sta	ted.	1) <sup>2</sup>	c. License r		88		Dater signed (Month		
<u> </u>		30. Name and address	i of person who co	impleted caruse of de	eath (Item 23a	(Type, Print)	OUTH	EAT	ONS	x. B.	ALTIME	REV	MD 219911
Regi	itate strar	31. Date filed (Month,	Day, Year)	32. Registra	r's Signature	hack .						0	4027

			1 - State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	ealth and I Death	Mental Hygie	ene 2001	38507
	Physici /Medic		1. Decedent's Name (First, Middle, La  WI I I AM	long		. , , .		2. Date of Death Month	Day Co Zoox	3. Time of Death
	Examin		4a. Facility Name (If not institution, biv	spital	last birthdav)	4b. City, Jown, or	Location of Death	2_	4c. County of Death	nplace (State or Foreign
	Funeral Director		015-50-5492 Usual Residence of Decedent	XM 2□F 77	Yrs.	Months Days	Hours Min,	8. Date of Birth (Month, Day, Y December	18,1926 (	China
	death with the Maryland rms 23s or 28s-f show f.rust be notified at	ctor	Maryland n/a		/, Town or Lo	ce				10d. Inside City Limits 1XXYes 2 □ No
	ath with the 23s or 2	Funeral Director	4012 Labyrinth Rd.			10f. Zip Code 21215			Citizen of What Co United St	ates
980	ours after death with ral', or Itams 23a or Examinet must be	by	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2 🏋 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: AS	e, etc.
Maryland 21215-0036	d within 72 hours after giene. giene. ir than "natural", or Ita ine Medical Examins	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12		(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired,	urina most of wor	rking 16	b. Kind of Business/l	
/land 2	s 1 and 2 should be filed within t Health and Mental Hygiene. itam 27 is marked othar than other traumatic avent, Ina M.	0	17. Father's Name (First, Middle, Last Ngon Lam				18. Mother's Nan Van Lui	ne (First, Middle, Ma		
, Mar	and 2 sho balth and I n 27 is me er traums	4 5	19a. Informant's Name/Relationship ( Xisong Lin/son-in-	* * * * * * * * * * * * * * * * * * * *	1	ng Address (Street a		ral Route Number, C Baltimo	ore, MD 2	ip Code) 1208
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	Bemoval from State	<sub>emetery, crer</sub> raine I	osition (Name of matory or other place Park Cemet	ery Dec.	6,2004 W	c. Location - City or 1	Maryland
Balt	permit. Departr Imports any inj		21. Signature of Fyneral Service Licer	Thell	22	2. Name and Addres Mitchel 6500 Yo	s of Facility L1-Wiede: ork Rd.	feld Funer Baltimor	cal Home, ce, MD 21	Inc. 212
	Physician /Medical		23a. Part. Enter the disease, or com- spock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line.  a	G. 2	ter the mode of dying	g, such as cardiad	or respiratory arrest	t,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ						
8760,	cate be executed obysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequent	uence of):					
Вох 68	eath certificate attending phys I for use as the	n/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of delin	/ery
P.O. Bo	at the death by the atte- tached for	hysician	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	Part II. Dther significant conditions of	contributing to death but not resu	ulting in the u	nderlying cause give	n in Part I.		cco use contribute to 2 □ No 3 □ Pro	
Vital Records,		e Compie	25. Was case referred to medical					24a. Was an autopsy performe	d2 death?	opsy findings available ompletion of cause of
of Vil	Physician: this certific al director,	To B	example?  1 Ves 2 No  27. Manner of Death		ER/Outpatier 28b. Time o		r: 4 🗆 Nursing H	ome 5 Residence 28d. Describe how	ce 6 Other (Spec	ify)
Division	Attanding Physician: r death. sctor: After this certifica y the funeral director.	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b		Injury	Work M 1□1	? /es 2 🗆 No			
Divi	ital or Ature after or ral Dirac	Certifi	4 Homicide determined	building, etc. (Specify	/) 			City or Town, S		
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director; completely filled in by the	Medicai	(Check only 2 Medical Exer	ysicien: To the best of my kno- niner: On the basis of examinal and manner stated.	wledge, deat tion and/or in	vestigation, in my op	inion, death occu	rred at the time, date	and place, and due	to the cause(s)
	with to con	2	29b. Signature and title of certifier	han		29c. License	2173	_	Date signed (Month	/
	Ċ		7	AN Sina	1/0	ospital				
	Sta Registi		31. Date filed (Month, Dal/Year)  DEC 0 6 2004	32. Registrar's Signa	ture	Sporter				

State of Maryland / Department of Health and Mental Hygiene 004 38508 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** PATRICIA ANN **ASPDIN** 11 17 2004 1:05 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pocomoke City

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 2350 Old Snow Hill Road Worcester Birthplace (State or Foreign Country)
 New Jersey 8. Date of Birth (Month, Day, Year) 11/28/1935 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 1 € F 68 Yrs. 145-26-7696 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Itams 23a or 28a-f show the Madical Examinar must be notified at 1 Yes 2 XNo Pocomoke City MD Worcester Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2350 Old Snow Hill Road 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status e filed within 72 hours after of Hygiene.
other than "natural", or Ital 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Po. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3. Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service Entrepenuer permit. Pagas 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William James Mackey Helen Louise (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 792 West Briar Ave., Toms River, NJ 09753 <u>Earl Aspdi</u>n (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 11/20/04 Salisbury, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Melson Funeral Home, P.A.
103 Linden Ave., Pocomoke City, MD Muchael rean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bronchogenic 5 mok 1275) 3 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and had for use as the burial-transit The law requires that the death certificate be exacuted Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown baan signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 2 No 1 Yes 1 Yes 2 3 No Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury al Work? Aftar 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation in by the within 24 hours after deatl To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 h451C11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature. State Registrar NOV 1 9 2004

State of Maryland / Department of Health and Mental Hygien 38509 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11/19/2004 **Physician** Adams Lola Η. 8:35 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Waldorf Healthcare Center Waldorf Charles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/24/1905 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 98 1 M XX F Yrs Director 579-32-0563 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Menial Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23c or 28a-f show any hijury or other traumatic event, the Madical Exurtinal Let collined at once. LaPlata 1 ☐ Yes 🛣 🗓 No Maryland Charles Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 USA 6255 Ripley Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ᠌∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X2XNo Specify: Specify: þ White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital File Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Robert Majors Alberta Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Adams / Nephew 6255 Ripley Rd. LaPlata, Maryland 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 11/23/2004 Suitland, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Lic <sup>22. Name and Address of George</sup> P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Kust 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nmediate Cause (Final sease or condition ARTERIOS 10UASCULAR ENOTTC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Day Year 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? XX No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: X4XXXVursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZXNo 2 ER/Outpatient 3 DOA 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: 1X X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral E 29a. Certifier 💥 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of d address of person who completed cause of death (Item 23a) (Type, Print) OLD LINE CENTER State Registrar

		1	For State	;	State of	Maryland	d / Depa	artment of He	ealth a Death	and Me	ental Hyg	jiene2	004	38510	
	ASS	A	Registrar  1. Decedent's Name (First,	Middle, Last)							2. Date of Dea	th		3. Time of Death	٦
	Physicia	-	David		- d	Arn	old.				Month	Day	Year	7:30 PM	
ī.	/Medic		ta. Fecility Name (If not in:	Elwo			010	4b. City, Town, or	Location o		lovembe	4c. C	2004 ounty of Dea	th	1
	Examin	er	9308 Liber	-		,,		Freder							
,			5. Social Security Number	6. Sex		. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birtl	1	reder 9. Bir	thplece (Stete or Foreign	-
	Funeral Director		217-76-5982	12	M 2□F	47	Yrs.	Months Days	Hours	Min.	ct. 17	, 1°957	9	Mary land	
			Usuel Residence of Deced	lent											
	/iand		10a. State 10b. (	County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Mar.	ō	daryland F	redericl	K	F	rederi	ck						1 ☐ Yes 2 📉 No	
	r 288	<u>ie</u>	10e. Street and Number					10f. Zip Code				10g. Citize	n of What C	ountry?	
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	deat ms	Funeral Director	11. Marital Status	12	2. Was Deced Armed Ford	ent Ever in U.S	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)	14	. Race - Am- Black, Whi	erican fndian, ite, etc.	
9	after or its		1 Never Married 2		t ☐ Yes 2 If Yes, Give	. No No		1☐ Yes 2X No					pecify: W	hite	1
2	urel',	d by	3 Widowed 4 Di		Year or Dat	es:							of Business		$\dashv$
Š	72 h 'natu	ete		ecedent's Educa highest grade			(Give	dent's Usuat Occupa kind of work done d DO NOT use retired;	luring most	t of workin	g	166. Kind	or business	vindustry	
121	within ne. then	Completed	Elementary/Secondary	(0-12)	Coltege (1-4	4or 5+)		umbing est		or		Plu	mbing		
7	lled v lygie ther t		17. Father's Name (First, I						18. Mothe	er's Name	(First, Middle,	Maiden S	umame)		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural; or items 23s or 28s-f show aumatic event, the Madical Examinar must be spulled at	Be c	Glenn Elwo		1 d				Car	olyn	McKenz	ie			
Ž	hould d Me mark mark	၉	19a. Informant's Name/Re				19b. Maili	ng Address (Street a					Town, State,	Zip Code)	
<u>S</u>	d 2 s th an 17 is i		Brenda L. A		_			Liberty (							
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke eny injury or other traumatic enges.		20a. Method of Disposition			20b. P	lace of Dispo	osition (Name of matory or other place	0)	D	ate	20c. Loca	tion - City o	r Town, State	
Baltimore,	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 🂢 Crer		moval from S			y Crematio		lov. 16	5.2004	Syke	svill	e. Md.	
	artme ortan injury	1	21. Signature of Amerat S		A	7		2. Name and Addres		ty Ha	ertzler	Fune	ral H	ome	
Ba	Depa Impo eny i		Coloni	00	-1	4.1		11802 Libe	erty	Rd.	Libert	ytowr	, Md.	21762	ļ
	1-50 t		23a. Pert1. Enter the dise	ase, or comptic	ations that ca	used the death	n. Do not en	ter the mode of dying	g, such as	cardiac or	r respiratory ar	rest,		Approximate tnterval Between	
			shock, or heart failu tmmediate Cause (Finat	re. List only one	e cause on ea	ch line.		,						Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a.	7< e	na / or as a consequ	rence of):	lare	. 4					weeks	$\dashv$
	Examiner				11	Van Ce	11	olorect	al	Ca	ucen			24ears	
Ę.,-	<del>(2</del> 9).	e e	Sequentially list condition if any, leading to immedia	s. ite b.	Due to (c	or as a consequ	uence of):	0001							
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1											
Ć.	exec in an	Еха	resulting in death) Last		Due to (c	or as a consequ	uence of):								
1760,	ate be executed hysician and the burial-transit	cal		€ d.											_
89	tificat ng phy as th														_
Вох	andir use	N/U	IF FEMALE: 23b. Was decedent pregi	nant 23		ome of pregnanth 2 Feta		☐Ectopic pregnancy				23	d. Date of de	elivery Day Year	
	0 0	icia	in the past 12 month 1 ☐ Yes 2 ☐ No	ns?		int at time of d		Other (specify)					MOHIT	Day	
P.0	by th	hys	9 Unknown			_									-4
S,	The law requires that the death ate has been signed by the atte bage 2 should be detached for	by Physician/Med	Part II. Other significant	conditions con	tributing to de	ath but not res	ulting in the i	underlying cause give	en in Part I	l.		ķ		to the cause of death?  Probably 4 □Unknown	
g	w require been si should?										1 🗆 '	es 2	, 3 J	Probably 4 Unknown	_
Record	awre Is be	plet									24a. Was		prior to	autopsy findings available completion of cause of	
	The law	Completed									perfo 1 ☐ Yes	med? 2 X No	death? 1 ☐ Ye		
Vital		BeC	25. Was case referred to	medical					26. Place	e of Death	(Check only o	ne)			_
	Physician: this certific ral director.	To	examiner? 1  Yes 2  No	Н	ospital: 1 ☐ Ir	npatient 2	<b>ER/</b> Outpatie		4 🗀 14	ursing Hor			□Other (Sp	ecify)	
n of			27. Manner of Death 1 Natural 5	Pending	28a. Date o (Month	f Injury h, Day Yeer)	28b. Time Intury	Wor	k?		28d. Describe I	now intury	occurred		
000	Attending r death. ector: After on the fune	atle	2 Accident	investigation Could not be					Yes 2					2 10 11 11	_
Division	irect irect	ertification:	3 ☐ Suicide 6 L 4 ☐ Homicide	determined		of Injury - At hing, etc. (Specif		treet, factory, office			City or To	vn, State)	Number or F	Rural Route Number,	
Ω	ital c	O													_
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 1	Certifying Phys Medicel Examin	er: On the ba	sis of examina	wledge, dea ition and/or i	th occurred at the time nvestigation, in my o	ne, date ai pinion, dea	nd place, a ath occurr	ed at the time.	date and p	olace, and du	as stated. ue to the cause(s)	
	the the	Med	29b. Signature and title of	of certifier	and mann	ier stated.		29c. Licens	e number			29d. Date	signed (Moi	nth, Day, Year)	_
			250. Signature and title of	/	_		-, M	n n	4	181	66	Nove	mber	16.2004	
7	WIL			- 1		4	7 220) (7	Print)		10		, 0 0 ,		.0/200/	_
	210		Kanan Hua	hud, M	D . 46		n 23a) (1ype	Tohrson	Drive	c; F	reder	ck.	wo.	16,2004 21702	
	St	ate	31. Date filed (Month, Da			egiarar's Signa	ature								
	Regist		N	OV 18	2004	Gazer .	18	Comet .							

DHMH 17 Rev 1/2001

**ORIGINAL** 

		1 - State Registrar 26 per Verb.	Partment of Health and Mental Hy Certificate of Death	Reg. No.
Physici		Earl F. Bailey	Novemb	Pay Year 0935 M
/Medio Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Zami		Memorial Hospital at Easton	Easton	Talbot
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Months   Days   Hours   Min.   (Month, Di	ay, Year) Country)
Director		220-26-7920	08/04/	31 Maryland
land ow		10a. State 10b. County 10c. City, Town	r Location	10d. Inside City Limits
Mary -f sh	ţō	MD Talbot	Easton	1 x Yes 2 □ No
be filed within 72 hours after death with the Maryland tal Hygjene. d other than "natural", or Items 23a or 28a-f show event, the Mcdical Expriment in usite anyther a	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th wit	alD	602 Winter Street	21601	United States
ems ems	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	o- 14. Race - American Indian, Black, White, etc.
or It	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dates: 48-52	1 ☐ Yes <b>2/EN</b> O <i>Specify:</i>	Specify: White
72 hours "natural",	d b		ecedent's Usual Occupation	16b. Kind of Business/Industry
in 72 in 8	Completed	(Specify only highest grade completed)	Give kind of work done during most of working fe. DO NOT use retired)	Top: Nind of Businessa Massay
with piene.	E	Elementary/Secondary (0-12) College (1-4or 5+) E1	ectronics/Maintenance	Electrician
othe othe	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
uid by Menta Irked	70 E	Guy F. Bailey	Thelma Majo	ors
nd 2 should be file Ith and Mental Hy 27 Is marked oth traumatic event	ľ	1 1 21 1	Mailing Address (Street and Number or Rural Route Numb	
and 2 eelth m 27			02 Winter Street, East	
of Hi of Hi If Iter		cemetery	isposition (Name of crematory or other place)  Veterans C 11/30/04	20c. Location - City or Town, State Hurlock, MD
Pag iment tant:		`4 □Donation 5 □Other (Specify)	. occians o.	·
permit. Pages 1 and 2 should be filed within 72 ho Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Mcdical once.		21. Signature of Funeral Service Licensee  Muhael 4. Gskaw	22. Name and Address of Facility Frampton Federalsburg, MD 2163	Funeral Home
ate be executed // Medical Examiner   Wasician and   Wasician and	Ical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter thicking Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of c. Due to (or as a consequence of d.	scular accident	Interval Between Onset and Death MINUTES
Attending Physician: The law requires that the death certificate be executed rideath. Secutional this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
uires that n signed b	þ	Part II. Other significant conditions contributing to death but not resulting in	and and any and and any and any and any and any and any any and any	tobacco use contribute to the cause of death?  Yes 2 \( \text{No} \) 3 \( \text{No} \) robably 4 \( \text{Unknown} \)
or Attending Physician: The law requires the death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed	hyperlyndemia	24a. Wa auto per 1   Yes	s an opsy 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 DNo
ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check only	one)
ding Physician: The Ing. After this certificate hat funeral director, page	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 SER/Outs		
ding Pl		27. Manney of Death  1 Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Year)  Injury	ury Work?	how injury occurred
death. ctor: A	Certification:	2 Accident investigation	M 1 Tyes 2 No	(Charles the second sec
or At fter d Nrect in by	E	4 Homicide determined 28e. Place of Injury - At home, fare building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical Ce	29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and		
thin 2 the mplet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Z 3 Z 8		1 1 1 1 0 0	H47357	11-22-2004
		20 slower and address of parent who completed around it does to the state of the st		
		30. Name and address of person who completed cause of death (Item 23a) (1	, po,	
		Anne L. Grady D.O., 82	21 Teal Dr. Suite 204	Easton, MD 21601

or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. within 24 hours after death.

To the Funeral Director: After this certificeta has been signompletaly fillad in by the funeral director, page 2 should I ş

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 XCould not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 XMedical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year) 29c. License number OCME November 24, 2004 Calcillah 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ZABILLIAH

Darka

State

Registrar

31. Dete filed (Month, Day, Year)

DEC 0 1

2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2001

				Cei	rtificate of		R	eg. No.	38513		
	Physician	1. Decedent's Name (First, Middle, Las	st)				2. Dete of Dee	th Dey Year	3. Time of Death		
-	/Medical	MARY RUT		KID			NOV.	8 2004	11:05 AM		
1	Examiner	4e Fecility Name (If not institution, give				4b. City, Town, or I		4c. County of Deat			
		101 CHESTNUT STI 5. Social Security Number 6. So		land historia.	If Under 1 Year	CENTREV		QUEEN			
	Funeral Director		© M 2 1 F 82	Yrs.	Months Days		8. Date of Birth (Month, Dey MAY 18,	Yeer) Co	hplece (State or Foreign untry) YLAND		
	yend	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits		
	Man	MD QUEEN	ANNE	CENTR	EVILLE				1X Yes 2 □ No		
	or 28	10e. Street end Number			10f. Zip Code		1	0g. Citizen of What Co	untry?		
	23a 23a rai E	101 CHESTNUT STRI	EET		2	1617		USA			
20	within 72 hours after death with the Maryland ena.  **Market of items 23a or 28a-f show he Madical Examiner must be notified at he majorated by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 XXY es 2 ☐ No If Yes, Give Yeer or Dates:		Was Decedent of F f Yes, specify Cub 1 ☐ Yes 2 No	lispenic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:			
8	"natural", or idical Exam leted by F	15. Decedent's Ed		16e, Deced	dent's Usual Occup	petion		16b. Kind of Business/			
21215-0020	be filed within 72 hor tal Hygiena. d other than "natura event, the Medical Be Completed	(Specify only highest green Elementery/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life. L	kind of work done DO NOT use retire	during most of word)	king		Haddily		
S.		12	7	NUR	SE			NURSING			
Maryland	should be filed within nd Mental Hygiena. marked other than 'metic event, the Me	17. Fether's Neme (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, I	Maiden Surname)			
<u>X</u>		CHARLES C. BARCI	JS			SARAH	MATILDA	SLAUGHTER			
ā	d 2 should th and Mer 7 Is marke traumatic TO	19a. Informant's Name/Relationship (7	• •	19b. Meilir	ng Address (Street	and Number or Ru	rel Route Number	, City or Town, State, 2	Tip Code)		
	s 1 and f Health item 27 other to	JOHN C. BESKID/SC				), CENTRE					
altimore,	Page nt: if iry or	20a. Method of Disposition  1 💆 Burial 2 🗆 Cremation 3 🗆 4 🗆 Donation 5 🗀 Other (Specify	Removal from State	emetery, cren	sition (Neme of natory or other ple CEMETER	1	Dete 1-12-200	20c. Location - City or QUEENS	Town, State  STOWN, MD		
Ball	permit. Departmineports Imports any inju	21. Signature of Funeral Service Licent	500	22 FF.	. Name and Addre	ss of Fecility	& NEWNAM	FUNERAL H	OME. P.A.		
	20260	I E All	1	40	8 S. LIB	ERTY ST.,	CENTREV	ILLE, MD 2	_		
4	-	23a. Part . Enter the diseese, or comp shock, or heart failure. List only of	lications that caused the deeth one cause on each line.	. Do not ente	er the mode of dyi	ng, such es cardiac	or respiratory erro	est,	Approximate Interval Between		
) I	Physician /Medical	Immediate Cause (Final disease or condition resulting in death)  August 100 Course May 100 Cours									
	Examiner	disease or condition resulting in death)	a. NON SWIG	a e	u Ca	LEGUV	Col CVII	wun	Thimpes		
	ē III		Due to (or	r es a conseq	NICLE	tul					
	be axecuted sician and bunial-transit		b		//	7					
o		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	D09 01 90 (01	res e conseq	derice oi).	/		}			
68760	ficate be physicials the but edical	Cause (Disease or injury that initieted events resulting in death) Last	c Due to (or	as e consequ	uence of):						
8	e es the	resulting in death) Last									
Box	eath ce ettendii for use		d					1			
0	law requires that the death ce as been signed by the ettendi t 2 should be detached for us, npieted by Physician/	Part II. Other significant conditions co	ntributing to deeth but not resu	ılting in the ur	nderlying cause giv	en in Pert I.	23b. Dld to	bacco use contribute	to the cause of death?		
<u>م</u>	d by t d by t letach						1 🗆 Ye	e 2□ No 3 DP	obably 4 Unknown		
က်	The law requiras the part of the same is t										
0	requi						24a. Was a	ned? a	Vere autopsy findings vailable prior to completion of cause		
Vital Records,	has the same of th							0	f death?		
<u></u>	ysician: The law als certificate has to director, page 2 s						t⊡ ¥e	is 2012 No 1	☐Yes 2☐ No		
= :	certific rector	25. Was case referred to medical examiner?	Hospital:		Ott		th (Check only on				
ō	Physic reliding reliding	1 ☐ Yes 2 ☐ No 27. Manner of Death	' 1 ⊔ Inpatient 2 ⊔ !	ER/Outpatien 28b. Time of	t 3 DOA	Vat		nce 6 Other (Spec	ify)		
5	Afte Afte	1 Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	Injury	28c. Injui Woo M 1□	k? Yes 2 □ No		injury coodinos			
DIVISION	al or Attending Physician: settar death. I Director: After this certific d in by the funerel director, certification: To Be (	3 Suicide 6 Could not be	286. Piece of injury - At ho	me, ferm, stre			28f. Location (St	reet and Number or Ru	rel Route Number,		
_	Far t	4 Homicide	building, etc. (Specify	')			City or Town	, Stete)			
	To the Hospital or Attending Physicial 24 hours effect death within 24 hours effect death completally filled in by the funerel medical Certification:	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my know iner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the tirestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)		
	Vithiu Vithiu Comp	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Month	, Day, Year)		
		I Max	VIV		D3988	4		11-9-04			
		30. Name end endress of person who c	ompleted cause of deeth (Item	23a) (Type, F	Print)						
		DAVID H. SMITH, 1			DRIVE, S	UITE 5, E	ASTON, M	D 21601	1		
	State Registrar	31. Date filed (Month, Pay, Year)	2004 32. Registrer's Signat	Jr. A	barte						
_				- 1			<u>.</u>				

		4	partment of Health and M <i>ertificate of Death</i>		iene g. Ko. 004	38514
Physic	sian	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
/Med	ical	BOBBY GLENN BURLESON, JR.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	NOVEMBE		04 8:45a M
Exami	iner	3015 KENT NARROWS WAY	Grasonville		QUEEN A	
Funera		5. Social Security Number  216-96-6394  6. Sex 1 ★ 2 F 7. Age (In yrs. last birthd)  27 Yrs	(av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, SEPT . 19,	9. 8 Year)	irthplace (State or Foreign Country)
Director	4	Usual Residence of Decedent		SEPT.19,	19// MA	ARYLAND
larylan show	5	10a. State 10b. County 10c. City, Town or MD QUEEN ANNE S CE	Location NTREVILLE			10d. Inside City Limits 1 X Yes 2 □ No
the N 28a-f	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What (	
ath wilf	ral D	105 HAYMAKER DRIVE	21617		USA	
13-0030 72 hours after death with the Maryland "natural", or flems 23a or 28a-f show idical Examiner must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1. Yes 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	cify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.
ours at	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 to No Specify:		Specify: WE	IITE
	letec	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of worki e. DO NOT use retired)	ng 1	16b. Kind of Busines	ss/Industry
filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	TAURANT MANAGER	1	FOOD INDUS	STRY
d tal	Be	17. Father's Name (First, Middle, Last)  BOBBY GLENN BURLESON	18. Mother's Name	(First, Middle, N	,	
and Ment and Ment is marked	2		ailing Address (Street and Number or Rura			, Zip Code)
ges 1 and 2 ges 1 and 2 it of Health a if Itam 27 is or other trai			HAYMAKER DRIVE, CE			
Pages 1 nent of H int: If Ita		1 🕱 Burial 2 □ Cremation 3 □ Removal from State cemetery, of	sposition (Name of rematory or other place)  ILLE CEMETERY 11-18		20c. Location - City of TEVENSVII	
그 원란 등 .		21. Signature of Fungal Service Licensee	22. Name and Address of Facility	_		
Dermi Depa Impo		M. M. Xu 4	ELLOWS, HELFENBEIN & OS S. LIBERTY ST.,	CENTREVI	LLLE, MD A	
	ı	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one sause on each line.				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	shot wound of	head	1	
Examiner						
ted nsit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury				
O, execu an and rial-tra	Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
The Court of the state of the s	edical	d				
ath certific	∿/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of d	elivery
death death death death	hyslcian/M	in the past 12 months?  1 Yes 2 No  1 Yes 2 No	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
ires that the death certifications by the attending	۵	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I	23e. Did tob	acco use contribute	to the cause of death?
requires nean signa	ed by			1 🗆 Yes	V'	Probably 4 Unknown
e taw requir	ompleted	1		24a. Was an		autopsy findings available ocompletion of cause of
	O			1 Yes 2	ed? daa(h?	
Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 X Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpai	26. Place of Death			ecitySCENE
ing Phys	on: T	27. Manner of Death  1 Natural 5 Pending (Month, Day et ) 28b. Time (Month, Day et )	of 5 28c. Injury at 2	8d. Describe hov	w injury occurred	, C
Wtandi death. ctor: A	ertification:	2 Accident investigation 1-15-04 8:	15AM 1 Yes 2 XNo	Subject	+ Shot	
talor A	Certi	4 Homicide determined building, etc. (Specify)	1	City r Town	State)	ou & Ca
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edical (	29a. Certifier (Check only (Ch	ath occurred at the time, date and place, a	nd due to the cau d at the time, dat	use(s) and manner a te and place, and du	as stated.
To the within 2 To the comple	Mec	one) and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Mor	
		Mati a follor mo	OCME	No	OVEMBER 1	5, 2004
101/V	48	Name and address of person who completed causers death (Item 23a) (Type 1111	e, Print) Penn Street, Baltimo	ore, Mar	vland 212	01
St	ate	TATISTIC POLITICAL TOTAL OF			,	T
Regist	trar	31. Date filed (Month, Day, Year) 32. Register's Signature NOV 1 7 2004	Aparle			

			. 101	artment of Health and Mental Hyg tificate of Death	giene 2004 38515	5
	Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year	
	/Medic	al	Leon Herbert Brooks	Novembe:	11100	l —
	Examin	er	4a. Facility Name (If not institution, give street and number)  Crescent Cities Center	4b. City, Town, or Location of Death  Riverdale	4c. County of Death  Prince George's	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth	9. Birthplace (State or Foreign	n
	Director		577-05-5074 1∑M 2□F 87 Yrs.	Months Days Hours Min. (Month, Day Mar. 29		
	land W		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	cation	10d. Inside City Limits	<u> </u>
	Mary a-f sh	tor	Maryland Prince George's	Riverdale	1 🗔 Yes 2 🗍 No	,
	ith the	Jirec	10e. Street and Number		10g. Citizen of What Country?	
	s 23a	rail	4409 East West Highway	20737	United States	
_	fter de	Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	Vas Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)		
D-0030	rat', o	by	3 ▼ Widowed 4 □ Divorced If ∀es, Give Year or Dates:	□ Yes 2XD No Specify:	Specify: Black	
2	e filed within 72 hours after death with the Maryland of Hygiene. other than "naturet", or Itams 23a or 28a-1 show vent, it a Medical Extention of the rectified at	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry	
7 7	withir lene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	Policeman	Government	
and	e filed Il Hygi other vent, I	a)	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,		_
ylar	Menta Menta arked atic e	ToB	Unknown	Mari	e Brooks	
Mar	permit. Pages 1 and 2 should be ilied within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Beginning or other traumatic event, it a Medical Exaculture content traumatic event, it a Medical Exaculture content traumatic event.			g Address (Street and Number or Rural Route Number 4 Overlook Trail, Ft. Was		
<u>ရ</u> ်	1 and Healt tem 2		20a Method of Disposition 20b. Place of Disposi	sition (Name of Date	20c. Location - City or Town, State	
Ē	Pages ient of int: If i		I Lybural 2 Cremation 3 Chemoval from State	t Cemetery 11/19/2004	Wash., DC	
Saltimor	srmit. spartm sporta ny inju			Name and Address of Facility Stewart I	Funeral Home	
-	20729		John! Slewart, [1]	4001 Benning Rd., N.E.		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, by heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory arr	Interval Between Onset and Death	
	/Medical		Immediate Cause (Final disease or condition resulting in death)  Sensis  Due to (or as a consequence of):		1 week	_
	Examiner		Congress of foot		1 month	
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa Uniscuss of injury  Peripheral Arter	27 No. 420 V V V V V V V V V V V V V V V V V V V		
•	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last  c. Peripheral Arter  Due to (or as a consequence of):	y Disease	year	
09/9	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dicai E	d			
8	certifical		IF FEMALE:			-
â	death ce e attendi	cian/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy	23d. Date of delivery  Month Day Year	
	the de	hysic	1 Yes 2 No 9 Unknown  4 Pregnant at time of death 5 9 Unknown	Other (specify)		1
, T	requires that the een signed by th hould be detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?	
ecord	equire			1 U Y	es 2□No 3□Probably 4 X️Unknown	
ပ	e fa has le 2	ompleted	<u> </u>	24a. Was a autops	sy prior to completion of cause of	)
	ician: The certificate ha	e Co	26 Was see relevant to medical		25 No 1 Yes 2 No	
5		0 0	25. Was case referred to medical examiner?  1 ☐ Yes 2 [X]No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (Check only on t 3 DOA Other: 4 XNursing Home 5 Reside		
0 0	ng Phys tter this neral di	n: T	27. Manner of Death 1 XNatural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		ow injury occurred	
VISION	tendik teath. tor: A the fu	ertification;	2 Accident investigation	M 1 Yes 2 No		
<u> </u>	after of Direct of In by	ertif	4 Homicide determined 28e. Place of Injury - At home, farm, streething determined building, etc. (Specify)	eet, factory, office 251. Cocation (Si	treet and Number or Rural Route Number, n, State)	
	To the Hospital or Attending Phyminin 24 hours after death.  To the Funeral Director: After the Completely filled in by the funeral	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and due to the c	ause(s) and manner as stated.	_
	the Ho nin 24 the Fu	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invaled and manner stated.			
	con con	Σ	29b. Signature and title of certifier	29c. License number 2 D25079	November 16 2004	
	600		30. Name and address of person who completed cause of leath (Item 23a) (Type, I		November 16, 2004	
	W.			cutive Pl., #502 Lanham-	Seabrook, MD 20706	
	Sta		31, Date filed (Month, Day, Year) 32. Registrar's Signature NUV 2, 2, 2004			
	Registr	ar	NOV 2 2 2004 Bleeve & Speck			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear Physician 14, 2004 8:35 a November Mary Louise Bresnahan /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Heartland Health Care Center Hyattsville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🕅 F May 23, 1918 Washington, 579-07-9508 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23c or 28a-1 show any injury or other traumatic event, I'm Predictal Exertified at tyE Yes 2 □ No Prince George's Hyattsville Maryland **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20781 U.S.A. 6000 42nd Avenue, Apt 414 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 21 No Specify Specify: White Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) National Elementary/Secondary (0-12) College (1-4or 5+) Rifle Association Membership Section 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Jenkins Harry Mackey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20781 5305 38th Avenue, Hyattsville, MD Walda J. Martin - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 11/18/2004 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service License 20781 4739 Baltimore Avenue, Nyattsville, MD Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the ceath. shock, or near failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Years Carcinoma Breast, Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Αq 1 Yes 2X No 3 Probably Dementia, Esophageal Dysmotility Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 has 1 Yes 2X No or Attanding Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 XNo 2 1 Yes s after death.
I Diractor: After this d in by the funeral d 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide a Funaral D letely filled in \*\*Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensbury Road, Hyattsville, Maryland 20781 Paul A. DeVore, MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

C

É	Physician /Medical Examiner
	Funeral Director

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	4.	- State Registrar			C	ertificate of D	eath		Reg. No.	004	3851
an	1.	. Decedent's Name (First, Middle	, Last)					2. Date of D			3. Time of Deat
cal ner	4a	Rosalie a. Facility Name (If not institution		sdale umber)		4b. City, Town, or i	ocation of Death			6, 2004 County of Death	
CI	1	Prince George's	Country	Hoenita	ī	Chever]			Dw	ingo Co.	
		223-42-4729	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs			f Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Februa	rth ay, Year) ry 2	1933 9. Birth Virg	orge's place (State or For intry) inia
	<u> </u>	Jsual Residence of Decedent  0a. State 10b. County		100.0	City, Town or	Location					10d. Inside City Lir
2	1										1X Yes 2 □
Director	10	MD Prince	e George'	S	Up	per Marlbor	0		10= Citi	zen of What Cou	
	'	11200 Whitehou	as Dead						rog. Ca		iniy:
erai	11	1. Marital Status		cedent Ever in	U.S. 1:	20774 3. Was Decedent of His	nanic Origin? (S	pecify Yes or N	0-	U.S.A.	ican Indian
by Funeral		1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed I	Forces? 2 🔼 No Sive		3. Was Decedent of His If Yes, specify Cuban  1 ☐ Yes 2 No		o Rican, etc.)		Black, White	
Completed		15. Decedent		1)	16a. De	cedent's Usual Occupative kind of work done du	ion Irina most of wor	kina	16b. Ki	nd of Business/li	ndustry
npi	Т	Elementary/Secondary (0-12)		(1-4or 5+)		ve kind of work done du . DO NOT use retired)		3			
Co	_			yrs	Off	ice Manager		400 · A414 ·		Private	
Be	17	7. Father's Name (First, Middle,					18. Mother's Nan	, , ,		Sumame)	
ို	-	Edward Henry B		<del> </del>				. Ransc			
	1	19a. Informant's Name/Relations		.1.		tiling Address (Street ar					
	-	Karen A. Barks	sdale/Dau			Dakside Lan	e India	nhead, l Date		and 206	
	20	1 ⊠ Burial 2 □ Cremation	3 Removal from		cemetery, c	rematory or other place	1		200. L0	cation - City or i	own, State
	L	'4 □ Donation 5 □ Other (S		На	rmony	Cemetery	11/2	22/04	Lan	dover,Ma	aryland
		21. Signature of Funeral Service	usha	ll		22. Name and Address 7474 Land	over Roa	d Lando	ver,		
	2	23a. Part1. Enter the disease or shock, or heart failure.	complications that only one cause or	caused the dea	ath. Do not	enter the mode of dying	, such as cardiad	or respiratory	arrest,		Approximate Interval Between
	d	Immediate Cause (Final disease or condition	Acres	A		/	3				Onset and Deat
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		Physici /Medic		1. Decedent's Name (First, Middle, Last) Frances Rosa	lie B	Barclay				2. Date of De Month	Day	Year 2004	3. Time of Death 433 PM
		Examin		4a. Facility Name (If not institution, give street and to Upper Chesapeake Medic		enter		b. City, Town, or Lo	Air	1	4c. County	of Death arfor	
		Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 F    Usual Residence of Decedent		(In yrs. last birth 84 Y			f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept.	h, Year) 16,1920	9. Birthpl Count Ma	ace (State or Foreign lry) aryland
		Maryland -f show fied ut	tor	10a. State 10b. County  Maryland Cecil	1	10c. City, Town	or Loca		Deposit			10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
		death with the Maryland rms 23a or 28a-f show finust be notified at	al Director	10e. Street and Number 25 Orchard Drive	1			10f. Zip Code	904		10g. Citizen of W	hat Count	*
33	36	irs after deat il', or Items 2	by Funeral	1 Never Married 2 Married 1 Yes,	Forces? s 2 ThNo			s Decedent of Hisp es, specify Cuban, Yes 2\ No	anic Origin? (Si Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	- 14. Race Black Specify:	- America , White, e	
9/	altimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital hygiene. od other then "natural", or Items 23a or 28a-1 show event, the Medical Existing or must be notified at	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College		-	Deceder (Give kii life. DC	nt's Usual Occupation of work done during NOT use retired)  Secretary	ing most of wor		16b. Kind of Bu Aberdeen Aberdeen	iness/Ind	ustry 7 ing Ground
	d 2	be filed within tal Hygiene. d other than event, the Me	Be Co	Eleven Years  17. Father's Name (First, Middle, Last)							Maiden Sumame		yrand
	ylar	2 should be n and Mental Is marked c	To E	Joseph Lawrence	Crawf						e D. Pop		
74	Mar	s 1 and 2 should f Heelth and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Lawrence A. Barclay, Sr	. (so			Address <i>(Street and</i> Montclare					
11/22/04	ore,	of Hee		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro				ion (Name of tory or other place)		Date	20c. Location - (		
12	tim	t. Pag tment tant: I		`4 ☐ Donation 5 ☐ Other (Specify)	m State		rk's	Cemetery		/27/04	Perryvil	1e,	Maryland
-	Bal	permit. Pages 1 and 2. Depertment of Heelth ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee	· ~ ~	50	Lee	Name and Address of A. Patterryville,	erson &	Son Fun	eral Hom	e, P	.A.
#395811	8760,	zate be executed / Medical and physician and the burial-transit the burial-transit was a second of the control	dicai Examiner	Sequentially list conditions, larry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a	consequence of	(f):	rebell	ar h	emen	hage		Approximate Interval Between Onsevand Death
nces	.O. Box 68	the death certific y the attending p iched for use as	by Physician/Med		e birth 2 gnant at tir	pregnancy Fetal death me of death		ctopic pregnancy other (specify)			23d. Date Mon		y Day Year
Fra	ords, P	law requires that as been signed b 2 should be deta	ted by Pt	Part II. Other significant conditions contributing to		not resulting in	the und	arlying cause given	in Part I.	†	obacco use contri /es 2 \( \subseteq No	bute to the	
24	al Rec	The ate h page	Completed	J'						24a. Was autor perfo 1 \( \subseteq \text{ Yes} \)	rmed? de	ere autop for to come ath? Yes	sy findings available ipletion of cause of
orcla	ion of Vit	ding Phys	ation; To Be	27. Manner of Death 28a. Da	Inpatient te of Injury onth, Day	28b. Ti		3 DOA Other.  28c. Injury at Work?	4 Nursing H		ne) dence 6 □Othe now injury occurre		
20	Division	or the	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Pla	ce of Injury Iding, etc.	y - At home, fam (Specify)	m, stree	t, factory, office		28f. Location (5 City or Tox	Street and Numbe vn, State)	r or Rural	Route Number,
		Hospital 24 hours e Funeral C etely filled	Medical	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the and m	the best of basis of e anner state	xamination and	death o	ocurred at the time, stigation, in my opini	date and place, ion, death occur	, and due to the rred at the time,	cause(s) and man date and place, a	ner as sta	ited. the cause(s)
		To the within 2 To the complet	Me	29b. Signature and title of certifier	Bree	an D		29c. License n		779	29d. Date signed	(Month, D	Pay, Year)
		6		30. Name and address of person who completed or	nuse of dea	ath (Item 23a) (T	Type, Pr	DO arford 1	0	C. 1. 1.	( L- 11	06	M ZOUT
		Sta Registi		31. Date filed (Month, Day, Year) 32	Registrar'	s Signature	N W	arjora /	1000	Jujie 10	3 1/ 3//	7	1047

			For State Registrar	State of I	Maryland / Dep Ce	artment of ertificate o		nd Mental Hy	giene	004	38519
18 11 18 3			Decedent's Name (First, Middle, La	ist)				2. Date of D Month		Year	3. Time of Death
Í	Physicia /Medic	al	Marie Louise Be					Novemb	er 17	2004	12:20 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give		er)		, or Location of	Death		ounty of Death	1
			52 Memorial Driv		Age (In yrs. last birthda)		ytown ar   If Under 2	4 Hrs. 8. Date of Bi		Carroll	unlace (State or Foreign
	Funeral Director			1□M 2 <b>∑</b> F	67 Yrs.	Months Day	/s Hours	Min. (Month, D Dec 13	ay, Year)		pplace (State or Foreign Intry) PA
	pu		Usual Residence of Decedent					100 1.			10d. Inside City Limits
	shov	'n	10a. State 10b. County		10c. City, Town or I	.ocation					1 ☐ Yes 2 ☐ No
	28a-f	Director	MD Car  10e. Street and Number	roll	Tan	2ytown 10f. Zip Code	9		10g, Citize	on of What Cou	
	3a or	Ö	52 Memorial Dri	Ve			21787			USA	•
	deatt	ner	11. Marital Status	12. Was Decede	ent Ever in U.S. 13	. Was Decedent of		in? (Specify Yes or N Puerto Rican, etc.)		Race - Amer Black, White	
98	72 hours after death with the Maryland Instural', or Items 23a or 28a-f show dicel Examinations to differ at	by Funeral	1 Never Married 2 Married	1 Tes 2-	R No	1 ☐ Yes 2 ☐ X		T sorto Triocari, Oto.,			nite
Ö	hours tural', al Ex	q pe	3 Widowed 4 Divorced	Year or Date	os:	edent's Usual Occ	cupation			d of Business/l	
5	n "na	plet	(Specify only highest gr	ade completed)	(Giv	e kind of work do DO NOT use ret	ne during most ired)	of working			
21215-0036	giene giene er the	Completed	Elementary/Secondary (0-12)	College (1-4	La La	nguage T	eacher		E	ducation	on
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las.	")			1	's Name (First, Middle		umame)	
<del>y</del> a	d Men narke	ဥ	Angelo Pupo  19a. Informant's Name/Relationship	(Tuna Brint)	10h Ma	line Address /Ctm		unknown)  r or Rural Route Numl		Town State 7	in Code)
Maryland	od 2 sl Ith an 27 le r traur		Raymond Beaumont			Memorial		Taneytowr		21787	p Code)
	is 1 and 2 of Health a item 27 le other trau		20a. Method of Disposition		20b. Place of Disposemetery, cr	osition (Name of ematory or other p	olace) 1	1/19/2004	•	ation - City or T	fown, State
imo	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special Control of C		Carroll				Ham	pstead	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Michical Examination and the collises at QDCB.		21. Signature of Foreral Service Lice	20 -			Funeral	Home and			
	1.		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cau	sed the death. Do not e	ter the mode of c	n <u>Lng ton</u> tying, such as c	ardiac or respiratory	arrest,	ter, M	Approximate Interval Between
100	Pnysician		Immediate Cause (Final disease or condition	$\Lambda \Lambda_{\Lambda}$	1 1	m (un	رن				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):						,
E.		-a	Sequentially list conditions,	b. Due to for	as a nonsequence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, loading to him solute cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	eath certificate be executed attending physician and for use as the burial-transit	Еха	resulting in death) Last	Due to (or	as a consequence of):						
8760,	ate be thysici the bu	Physician/Medical		d						-	
9	ding p	/Mec	IF FEMALE:	23c. If yes, outco	me of pregnancy					od Data at dall	
Вох	death certific e attending p id for use as l	clan	23b. Was decedent pregnant in the past 12 months?	1☐Live birtl	h 2 Fetal death 3	□Ectopic pregna □ Other (specify)			23	Id. Date of deli- Month	Day Year
P.O.	oy th ache	hysl	9 Unknown	9□ Unknow	n						
	w requires that been signed b should be det	by P	Part II. Other significant conditions	contributing to deal	th but not resulting in the	underlying cause	given in Part I.		_		the cause of death?
ord	law requires as been sign 2 should be	ted	Dicuxiti	× (1110) 16	1/68 11			-   '	Yes 2 🗷	No 3 Pro	bably 4 Unknown
Vital Records,	e la has	Completed	typhtens	im				24a. Was		24b. Were aut prior to o death?	opsy findings available ompletion of cause of
a	T ate	e Co	25. Was case referred be medical	1			00 Di	1 ☐ Yes	2 No	1 🗌 Yes	2 No
Ξ	Physician: this certific ral director,	0 8	examiner?	Hospital:	patient 2 ER/Outpati	ent 3 DOA	Othor	of Death (Check only sing Home 5 Res		□Other (Spec	ify)
J of	ding Phys n. After this funeral di	n: T	27. Manne of Death 1 Natural 5 Pending	28a. Date of (Month,				28d. Describe			
Sior	Attending ir death. ector: After by the fune	catlo	2 Accident investigation	on			☐Yes 2☐N				
Division	al or Attence after death	Certification;	3 Suicide 6 Could not 1 4 Homicide determined	200. Flace 0	Injury - At home, farm, s , etc. (Specify)	treet, factory, offic	ce		(Street and wn, State)	Number or Rui	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bi miner: On the bas and manne	est of my knowledge, de- is of examination and/or r stated.	ith occurred at the nvestigation, in m	e time, date and y opinion, deat	f place, and due to the h occurred at the time	cause(s) a , date and p	nd manner as lace, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1/1/1	MA	29c. Lice	ense number	,	29d. Date	signed (Month	, Day, Year)
	2	3	,	1001	7710		0 55180	1	10000	mhir	17,2004
	490,		30. Name and address of person who	Kushnu	- 114 B	usinesi (.	anth f	Inve Rei	} + R p.	in, MA	2/136
	Sta Registr	- 29	31. Date filed (Month, Day, Year)  NOV 1 9	2004 32. Re	strar's Signature	Coast ,					
					-	-					

State of Maryland / Department of Health and Mental Hygiene 38520 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Louise Alice Cornnor November 20,2004 /Medical 4.07 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly

If Under 24 Hrs.

Min. Prince George's Hospital Center Prince George's 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√2F Months 83 Director 578-30-3692 Usual Residence of Decedent 6/20/21 Wash.,D.C. the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 916 Eastern Ave., N.E. # 201 20019 or Items 23a U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) med Forces.
☐Yes 2 No filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 PV If Yes, Give 1 Yes 2 No Specify: Black 3 □ Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bur. of Engraving then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygient important: if them 27 ie marked other the any injury or other traumatic... U.S. Government Stampsheet Examiner 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Gordon Lillian Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia A. Gibson/Daughter 7100 E. Cedar St., Landover, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 11/26/04 Landover, Md. 21. Signature of Funerat Service Licensee 22 Name and Address of Facility & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition encephalopath. Physician anoxic /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 30120105 Due to (or as a consequence of): the attending physicien Box 68760 Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. | 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed rena 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manner of Death (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No death Director: 6 Could not be determined 3 ☐ Suicide in by t Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 20, 2004 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Prince 32. Registrar's Sig State Registrar

			1 - State Registrar	State of Ma	aryland / De		of H	ealth a		ental Hyg		004	38	521
	Physicia		Decedent's Name (First, Middle, La.	•	EDWARD	CARBE	RRY			2, Date of Dea Month	ith Day	0 0 4	3. Time o	
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, 1	Town, or	Location o		NOV . 1		ounty of Deatl		
			CARROLL HOSPIT					NSTE				RROLL		
	Funeral Director		5. Social Security Number 6. S 214-18-1226	ex 7.Ag M∑M2□F	e (In yrs. last birthda 82 Yrs.	(y) If Under Months	1 Year Days	If Under :	Min.	8. Date of Birth (Month, Day 4 / 2 4 /	Year)	9. Birth	nplace (State untry) YLAND	or Foreign
1			Usual Residence of Decedent		02					4/24/	1922	MAR	YLAND	
	how		10a. State 10b. County		10c. City, Town or	Location ONSVIL	TE						10d. Inside (	City Limits
	8a-1 o	Director	MD. MONTGO	MERY	DOKI									00 [48 s
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õ	n 72 hours after death with the Marylar "naturel", or flems 23a or 28a-1 ehow solical Examinar maral be politified at		1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ I If Yes, Give	No	1 Yes, speci			i, Puerto I	rtican, etc.)		Black, White	e, etc. HITE	
003	hours after turel', or ite	ed by	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's Ed	Year or Dates:		cedent's Usual						of Business/l		
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717	ed within giene.	Completed	1 1	College (1-40)	3+)	SAL	ESM	AN			AUTO	MOBIL	E	
and	be filed stat Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)  MARTIN		CARBERRY	7 CD			r's Name IMA	(First, Middle, TITUS	<b>Maiden</b> Su	mame)		
32	hould d Mer marke matic	ဥ	19a. Informant's Name/Relationship (			•				/ Route Number	r City or Tr	num Stato 7	in Code)	
Z	s 1 and 2 should f Health and Mer Item 27 Is marke other treumatic		JOAN M. DELKER			_				TMINST				
nore,	8° = 5		20a. Method of Disposition  1  Burial 2  Cremation 3  Other (Specific	Removal from State	20b. Place of Dis cemetery, c	position (Nam rematory or oth NTY CR	e of her place REMA	TION	л 1 11	ate /16/04	20c. Locat	ion - City or 1	Town, State	D.
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			23a. Part / Enter the disease, or com shock, or hear failure. List only	plications that caused								K, MD	Approxima	ite
	Physician		Immediate Cause (Final disease or condition	one cause on each III	ute ~	ena	A	10	1/2	0			Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):			7	7 (1				000	
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OX PR	the death certificate be executed the attending physicien and iched for use as the bunat transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							234	. Date of delin	(BD)	
מ	death e atter	iciar	in the past 12 months?	4 Pregnant at		3 □Ectopic pre 5 □ Other <i>(spe</i>					200	Month	Day	Year
т Э	thet the death ed by the atte detached for	hys	9 Unknown	9□ Unknown		-				-				
S,	se us	þ	Part II. Other significant conditions of	ontributing to death b		underlying ca	iuse give	n in Part I.		23e. Did to		contribute to	the cause of bably 4	
cords	req hon	eted		9,100	/	1 50	JC			-	/			
ď)	sician: The law s certificate has b lirector, page 2 s	Completed								24a. Was a autops perfor	med?	death?	ompletion of	cause of
VIII	an: T tificat tor, pa	a	25. Was case referred to medical					26. Place	of Death	1 Yes		1 🗆 Yes	2∐ No	
01 0	Physiclan: r this certific rat director,	To B	examiner? 1  Yes 2	Hospital:	nt 2□ER/Outpat	ent 3 DO	A Othe			ne 5 🗆 Reside		Other (Spec	ity)	
ס	ing Pl	ü.	27. Manner of Death 1. ■Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury		Bc. Injury Work			8d. Describe h	ow injury o	ccurred		
DIVISION	death ctor: ,	licat	2 Accident investigation 3 Suicide 6 Could not b		ury - At home, farm,	M street factory		′es 2□h	-	8f. Location (Si	treet and N	lumber or Ru	ral Boute Nur	nher
2	alor A s after ol Dire	Certificati	4 Homicide determined	building, et	c. (Specify)	on out, radiory,	OIIIOB			City or Town		311007 07 7107	277100101401	11001
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)  Certifying Ph	ysician: To the best niner: On the basis of and manner sta	examination and/or	ath occurred a investigation,	it the tim in my op	e, date and inion, deat	d place, a	and due to the co	ause(s) and ate and pla	d manner as	stated. to the cause(	s)
		Me	29b. Signature and title ol certifier	wel M	9		License					igned (Month		
	WILLY		30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	e, Print)	e L	RIVE		West	LMI	ster	- 7	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature						MD	211	)/	
	Registr		NOV 1 6	2004		South								
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	•	1- For State of Maryland / Department of Health and Months of Health and Health a		giene Reg. N2 0 0 4 3 8 5 2 2
Physici			2. Date of Dea Month	ath 3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  FILE MEMORIES (If not institution, give street and number)  4b. City, Town, or Location of Death  FILE MEMORIES (If not institution, give street and number)		4c. County of Death
Funeral Director			8. Date of Birt (Month, Da	9. Birthplace (State or Foreign Country) MARYLAND
		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	TAK. ZI	10d. Inside City Limits
ath with the Maryland at wet be notified at	ctor	MD QUEEN ANNE'S CHESTER		1 ☐ Yes 2 <b>X</b> No
death with the ms 23a or 28a	Director	10e. Street and Number 104 DOMINION LANE 21619		10g. Citizen of What Country?  USA
death death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Views) Armed Forces?	cify Yes or No	
Edward Maryland 21215-0036 Baltimore, Maryland 21215-0036 Bernit. Pages I and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hism 27 Is marked other than "natural", or Itams 23e any injury or other traumatic event, the Madical Examinational Approx.	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Specify: WHITE
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d 2121 d 2121 filed within "Hygiene. ther then "		Elementary/Secondary (0-12)  9  College (1-4or 5+)  WAITRESS  18. Mother's Name	/First Middle	RESTAURANT
yland yland outd be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last)  WILLIAM L. BRYAN, SR.  CHARLOTT		Maiden Sumame)
Maryla Maryla d 2 should th and Men it; 1 s marke traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural  CEODOGE I EDITARDO III (Type, Print)		
UU Sre, M ss 1 and 2 of Health litem 27 r other tre		comptant or material or other place)	STER, P	MD 21619  20c. Location - City or Town, State
Pages ment of ann: If its ury or o		1 & Bunal 2 Cremation 3 Hemoval from State 1 Donation 5 Other (Specify)  STEVENSVILLE CEMETERY 11/17	_	STEVENSVILLE, MD
Balti Permit. Departm Imports any inju		21. Signature of Funeral Service Incenses  22. Name and Address of Facility FELLOWS, HELFENBEIN 106 SHAMROCK ROAD,	& NEWN CHESTER	IAM FUNERAL HOME, P.A.
		23a. Fan1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a Due to (or as a consequence of):		years.
Examiner		Sequentially list conditions b. Severe walnu Trition		moultis
utad d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		mouthe.
3760, ate be exacutad nysician and he burial-transit		resulting in death) Last  Due to (or as a consequence of):		use alch
68760, tificate be en appropriate to a set to burie	fedical	7		7,000
Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IFFMALE: 23b. Was decedent pregnant in the past 12 mg/mths? 1  Yes 2 Ptho 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery  Month Day Year
ds, P.  Lires that  signed by d be deta	by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Nou Insulin debendent diabeth wellites		obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Munknown
ecords law require as been sig	Completed	Non insulin dependent diabetu welluten Hyperteunou Penmeral varcular direcus	24a. Was	an 24b. Were autopsy findings available prior to completion of cause of
f Vital Rec ysician: The law is ceruficate has t		Penpheral varcular directe	perfó 1 ☐ Yes	rmed? death? 2 No 1 Yes 2 No
Yita ysician ysician director	o Be	20. Place of Death		nne) dence 6 Other (Specify)
on of ing Phi	lon: T	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of linjury 28c. Injury at 28c. Injur		now injury occurred
Division of Vital Records, tor Attending Physician: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be control of the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (5 City or Tox	Street and Number or Rural Route Number, vn, State)
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the e	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within To the comp	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		11/13/04.
8KK		CVED AT A D COC TRUBILLY AVENUE FACTOR MD 21/01		
Sta Registi		31. Date filed (Month, Ray Year), 6 200 4 Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** NOVEMBER 5, 2004 6:00 A<sup>M</sup> ANNE KENDALL GILBERT-KOEPPL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL 749 HOWARD'S LOOP ANNAPOLIS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Dey, Yeer) 5. Social Security Number 9. Birthplace (Stete or Foreign **Funeral** 1 ☐ M 2 🗙 F 32 214-13-6023 OCT. 31, 1972 OHIO Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show the Medical Exertitive count be notified at 1 ☐ Yes 2X No Director ANNAPOLIS ANNE ARUNDEL MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA items 23a 749 HOWARD'S LOOP 21401 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ann of Health and Mental Hyglene.
ann of Health and Mental Hyglene.
The marked other then "natural", or flee ury or other tearmatic event, the Madical Examiting ury or other tearmatic event, the Madical Examiting 1 Never Married 2 Married 21215-0036 Specify: WHITE 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLINICAL PSYCHOLOGIST PSYCHOLOGY 5+ 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GARY P. GILBERT SUSAN ALLBURN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PETER M. KOEPPL, PHD./HUSBAND 749 HOWARD'S LOOP, ANNAPOLIS, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if eny injury or once. ° 4 ☐ Donation STEVENSVILLE CEMETERY 11/08/2004 STEVENSVILLE, MD 5 Other (Specify) 21. Signature of Puperal Parice Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that outsed the shock, or heart failure. List only one cause of each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) PNO MA **Physician** YIZHUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): 68760 Physician/Medical the Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month jo in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 ☐ Yes 2 ☐ No ONESS certificate 1 ☐ Yes Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 58 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 | Homicide To the Funaral Dir 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifia

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4TKIS

NOV - 8 2004

TARLET

32. Registrar's Signature

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Bests to DD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State C		irtment of Health an tificate of Death	d Mental Hygie	/ 11 11 14	38524
	°0		. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al -	Martha Isabel Hudson			November 2		12:40 AM M
	Examin	Çı	a. Facility Name (If not institution, give street and no		4b. City, Town, or Location of D	Death	4c. County of Death Washingto	n
			Homewood Retirement Cent Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Williamsport    H Under 1 Year     H Under 24	Hrs. 8. Date of Birth	9. Birthol	ace (State or Foreign
	Funeral Director	1	264-16-8918 1□ M 2 <b>∑</b> F	93 Yrs.	Months Days Hours	Min. (Month, Day, You March 18, 1	ear) Coun 1911 Mary	
	ט	· -	Usual Residence of Decedent	10c. City, Town or Lo	action		11	0d. Inside City Limits
	arylar show		10a. State 10b. County					1 ☐ Yes 2 🔂 No
	he M	Director	MD Washington  10e. Street and Number	Williamsp	ort 10f. Zip Code	10g	. Citizen of What Coun	try?
	with				21795		USA	
	death	Funeral	16505 Virginia Ave.  11. Marital Status  12. Was Dec	cedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P		14. Race - Americ Black, White,	
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show important: If item 27 is marked other than "naturel", or item, ust be notified at once.	Fur	1 ☐ Never Married 2 ☐ Married 1 🛣 Yes	ive 1940-43	1 ☐ Yes 2 ☑ No Specify:	dorio i libari, otory	Specific	
003	urel',	d by	322 VAIDOMED 1 DIVOTORD 1 FEB. OF	Dates.	dent's Usual Occupation	16	b. Kind of Business/Inc	hite
15-	n 72 i	Completed	15. Decedent's Education (Specify only highest grade completed	(Give	kind of work done during most of DO NOT use retired)			,
212	yiene.	mo I	Elementary/Secondary (0-12) College 12 th	(1-4or 5+) Nu	ırse		Medical	
פ	a filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)			Name (First, Middle, Ma	_	
Maryland 21215-0036	should ba find Mental I s marked o umetic eve	2	Daniel Strobel Schneb	ie Edith Cur		Code		
Jar	2 sho		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number of Washington St. P.O			
	1 and Health em 27 ther tr	F g	William Young / Persona  20a. Method of Disposition	20b. Place of Dispo	osition (Name of		c. Location - City or To	
nor	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State	crematorium No	v. 24, 2004 S	mithshim M	)
Baltimore,	permit. P Departme Importan eny injur		21. Signature of Euneral Service Lith nisee		2. Name and Address of Facility	Gerald N. N		
m	Depar Impor eny ir pnce.		Can- HA	30	05 N. Potomac S	t. Hagerstow	m. MD 2174	
	Physician /Medical Examiner	er.	Sequentially list conditions, b. Due to	caused the death. Do not entered hine.  (COUT)  (or as a consequence of):	7 CANXOVA	RCCCIA	)soze	Approximate Interval Between Opset and Death
,0928	icate be executad physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c	o (or as a consequence of):				
O. Box 6	that the death certifi ad by the attending detached for use as	Physician/Me	23b. Was decedent pregnant	gnant at time of death 5[	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
rds, P	es gu	þ	Part II. Other significant conditions contributing to	death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	acco use contribute to to	he cause of death?
Record	e law has b je 2 s	Completed	BRONCHITIS			24a. Was an autopsy perform	prior to co	ppsy findings available impletion of cause of
Vital	ilcian: Th certificate rector, paç	Bec	25. Was case referred to medical examiner?		Other	of Death Check onl one		
of \	this all dir	7		☐ Inpatient 2 ☐ ER/Outpatiente of Injury 28b. Time of	int 3 DOA 4 Nurs	sing Home 5 Residen 28d. Describe how		(y)
	ing After une	tlon	1 Natural 5 ☐ Pending (M	onth, Day Year) Injury	Work?   M   1 □ Yes   2 □ No			
Division	al or Attending safter death. ! Diractor: Afte d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, siding, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rur. State)	al Route Number,
	To the Hospitel c within 24 hours at To the Funerel D completely filled in	edicai C	(Check only 2 Medical Examiner: On the	the best of my knowledge, dea basis of examination and/or in anner stated.	th occurred at the time, date and nvestigation, in my opinion, death	place, and due to the cau	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and the biggetifier	X	29c. License number	29	d. Date signed (Month,	Day, Year)
		1	MENT WET	(A) (act	n 1)170	26)	1115415	004
L	4-3K1		30. Name and address of perion who completed ca	ause of death (Item 28a) (Type	Print) 1 1 1 77473	WHIE	HAPPEN	TOUN)
2		oto	31. Date filed (Month, Day, Year) 32	. Registrar's Signature	17 / Wallie	010-	11/19	-
	St Regist	ate trar	NOV 2 4 2004	Berein B. D.	seeke		Mo	11747

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 2230 M **Physician** 2004 November 20 Henry Wayne HUFF /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 9, 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Months Days 1 № M 2 □ F 69 Ĩ935 Virginia 225-40-0342 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County or 28a-f show other traumatic event. The Medical Examiner must be multilled at 1⊠Yes 2 No Washington Hagerstown Director Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA death with 21740 281 Ross Street or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iter any injury or other traumatic event. Ite Marical Examples 2008. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 🛣 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) construction construction 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Baker Henry Jackson Huff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1311 West Church St., Hagerstown, Md. 21740 Deborah Lashbaugh - companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/24/04 Greenlawn Mem. Park Williamsport, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Euneral Service Licenses 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) knowe Obstructive ica is Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown TOMORY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' 2 [ No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 27. Manper of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760. or Attending Physician: after death. in by the To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howell 21742 Hord 33 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year) NOV 2 3 2004

4 | Homicide

29a. Certifier

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Ecritiving Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

			State	Maryland / Depa	artment of Healt		al Hygien	2001	20506
			Registrar  1. Decedent's Name (First, Middle, Last)		imoute or Bea		ate of Death	e U U i i	3. Time of Death
	Physici	an	MARIANA F. HOBSON			M	onth Da	ay Year 18, 2004	2:55 p M
	/Medic		4a. Facility Name (If not institution, give street and numb	ber)	4b. City, Town, or Loca			c. County of Deat	
	Examin	er	St. Thomas More Nursing &		Hvattsvil	10	D	rince Ge	omosta
	Funeral		5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year If U	Inder 24 Hrs. 8. Da	ate of Birth	9. Birtl	nplace (State or Foreign
	Director		230-34-3919 1□M 2\(\text{\text{M}}\)F	87 Yrs.	Months Days Ho		b. 12,		Jersey
	pr ,		Usual Residence of Decedent	10c. City, Town or Lo					10d. Inside City Limits
	show	_	10a. State 10b. County						1. Yes 2 No
	8a-f	Director	Maryland Prince George's	Upper Ma			100.0	itizen of What Co	
	with ti		10e. Street and Number		10f. Zip Code				untry
	s 23	Funeral	13216 Whiteholm Drive	lent Ever in U.S. 13. \	20774 Was Decedent of Hispani	ic Origin? (Specify )		S.A. 14. Race - Ame	ncan Indian.
	item item	S .	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married	es? I	f Yes, specify Cuban, Me	exican, Puerto Rican	, etc.)	Black, White	e, etc.
36	irs af	by F	3 ☑ Widowed 4 ☐ Divorced Year or Dat		1 ☐ Yes 2X No Spe	ecify:		Specify: B1	ack
ò	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or items 23e or 28a-f show event, the Medical Examinar must be notified at	ted	15. Decedent's Education	16a. Deced	dent's Usual Occupation		16b.	Kind of Business/	Industry
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21	filed withi Hygiene. other than ent, the M	Completed	3	Nurse				ivate In	dustry
b	al Hygie I other went, L	Be (	17. Father's Name (First, Middle, Last)		18. N	Mother's Name (Firs	t, Middle, Maide	n Sumame)	
<u> a</u>	should be ind Mental s marked o umatic eve	2	Nathan Waltus Freeman		M	innie LaR	oche		
Maryland 21215-0036		9	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and N				
	2 # Z		Linda Matthews - Daughte		Buchanan St	reet, NE,			
Baltimore,	Pages 1 au nent of Hea ent: If item ury or othe		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 🕅 Removal from S	tate   -	matory or other place)	1		Location - City or	
Ē	permit. Pages Department of Importent: If it any njury or o		`4 □Donation 5 □ Other (Specify)		Baptist Cemet				
Sall	permit. Deporting Importe any njt		21. Signature / Fineral Service Licensee		2. Name and Address of F				
	70 = a 0		Jahuel Franky		739 Baltimon			LIIe, MD	20/81 Approximate
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<b>\</b>	Physician		resulting in death)	Renal Failu	re				Days
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Records,	w requir been si should	Completed by	Spinal Stenosis, Breast	Cancer			1 🗆 Yes	2 X 140 3 1 F1	ODADIY 4 DONKIOWII
ec	has be	ble					24a. Was an autopsy	prior to	topsy findings available completion of cause of
= H		Con				1	performed? ☐ Yes 2 💢 N		2 🗆 No
of Vital	Physicien: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?		Other	Place of Death (Cho	1100		055
of C	Physi this c al dir	2		patient 2 ER/Outpatier		Nursing Home	5 Residence Describe how inj		cify)
n c	ding F	lon	27. Manner of Death 1 X Natural 5 ☐ Pending (Month	n, Day Year)	of 28c. Injury at Work?  M 1 □ Yes		Describe now in	dry occurred	
isio	Attending in death.	cat	2 Accident investigation 3 Suicide 6 Could not be	of Injury - At home, farm, str			ocation (Street	and Number or Ru	ural Route Number,
Division	of or Attend after death Director: /	Certification;	4 Homicide determined 256. Flate of buildin	g, etc. (Specify)	iodi, radiory, omoo		City or Town, Sta		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	0	29a. Certifier 1X Certifying Physician: To the	best of my knowledge, deat	th occurred at the time, da	ate and place, and d	ue to the cause	(s) and manner as	s stated.
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Examiner: On the ba	sis of examination and/or in					
	To the within 2 To the complex	₹	29b. Signature and title of certifier		29c. License nun	mber	29d. D	ate signed (Mont	h, Day, Year)
	, , , ,		* Kaman R. T	ali, del	D1960	09.	Nov	ember 18	, 2004
HW	10		30. Name and address of person who completed cause	of death (item 23a) (Type,	Print)		1 2.2		
14	,0		Raman Tuli, MD 3503 Per	ry Street, Mo	ount Rainier	r, Marylar	d 20712		
		ate	31. Date filed (Month, Day, Year) 32.76	egistrar's Signature	ade	•			
	Regist	rar	NOV 2 2 2004 1	ever it for					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROBERT HARRINGTON Μ. 0455 November 2004 /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death **Examiner** EASTUN HOSPITAL MEMORIAL TALBOT 8. Date of Birth (Month, Day, Year)

June 9,1932 Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Months Days Hours Min 1 XM 2 F 218-24-5673 72 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner near be notified at MD Caroline No Yes 2 No Federalsburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Bloomingdale Avenue 21632 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: 153-55 Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, In Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) Prison Guard Corrections 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Harrington Lucy Chance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda W. Moore/Niece 7929 Laurel Lane. Denton, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/24/04 Hurlock, Maryland \* 4 □ Donation 5 □ Other (Specify) Eastern Shore VA 22. Name and Address of Facility Framptom Funeral Home, PA Funeral Service Licenses 216 North Main St.Federalsburg, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Nummia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MACL Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury Due to (or as Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24a. Was an autopsy performe 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on spital: 1 Inpatient 2[ 28a. Dule of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: P 2 ER/Outpatient 3 DOA 27. Manner of Death

Natural

Accident 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

burial-transit or Attending Physician: The law requires that the death certificate be executed attending physician Box 68760, P.O. Division of Vital Records, this after death.

Director: After to in by the funeral pelli within 24 hours a To the Funeral L

or 28e-f show

or items 23a

3altimore, Maryland 21215-0036

6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 00053110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis DeShields, 219 S. Washington St. Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

2 9

Medical

			For Amen State Amen Registrar			State c er fh	f Man G842	yland 4 6-3	o Per Ce	artmen tas rtificat	t of H	ealth a	and M			2004	385	
	Physici	an	1. Decedent's Name Harold		Hi	L1								2. Date of I Month Nov.	Day	, 2004	3. Time of 0235	
	/Medic Examin		4a. Facility Name (II	not institutio	n, give st	reet and nu	ımbər)			4b. City,	Town, or	Location	of Death		4c.	County of De	ath	
1			4421 E.	N. M	ct	Rhod	esda	le F	≀d.	Hu	rloc	ck			D	orche		
	Funeral Director		5. Social Security N 2 3 0 - 0 3 - 3 2 3 0 - 0 3 - 3 Usual Residence of	282	6. Sex	M 2□F	7. Age (li	n yrs. lasi 85		Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, 1	Birth Day, Year) 119	9. B V <b>i</b>	irthplace (State of Country) rginia	r Foreign
	and	-	10a. State	10b. County	,		10	0c. City, T	Town or L	ocation							10d. Inside Cit	y Limits
	Mary f sho	ō	MD	Doro	hes	ter				H	urlo	ck					1 ☐ Yes	2 <b>\</b> \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	r 28a	irec	10e. Street and Nur	nber						10f. Zip					10g. Citi	zen of What C	Country?	
	th wit	ai D	4421 E.	N. Mk	t	Rhode	esda.	le R	d.		216	43			Uni	ted S	tates	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, the Mardical Excitit har must be indiffed at	by Funeral Director	11. Marital Status 1 ☐ Never Marri		ried	2. Was Dec Armed F 1 Tes If Yes, G Year or E	M∑MNo ive	er in U.S.	13.	Was Dece If Yes, spe 1 \( \text{Yes} \)				ecify Yes or I Rican, etc.)	No-	14. Race - Am Black, Wh Specify: W		
5-0	72 ho	eted	(Spec	15. Deceder	nt's Educ	ation completed)	)	1	16a. Dece	edent's Usu e kind of wo	al Occupa	ation during mos	t of work	ing	16b. Ki	nd of Busines	s/Industry	
21	within ene. than "	Completed	Elementary/Seco				(1-4or 5+)	P		bing				,	Pl	umbin	a	
121	iled w Hygiel ther ti		12 17. Father's Name	(First Middle	Last)				_ unit	DING	COII			e (First, Mida			9	
and	d be f	To Be	Joseph											Hill		,		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Ma	ř.	19a. Informant's Na	me/Relation:	ship (Typ	e, Print)			19b. Mail	ing Address	(Street a				nber, City o	r Town, State,	, Zip Code)	
N	alth al		Steven	W. Gu	ess	ford/	'Son		442	1 E.N	1. M	kt-R	hod	esdal	e Rd	Ни	rlock.2	1643
Baltimore,	90=5		20a. Method of Disp 1 🔀 Burial 2 [ 3 4 □ Donation	Cremation		moval from	0	20b. Plac	e of Disp	osition (Na matory or d ashir	me of other plac	e)		Date 23/04	20c. Lo	cation - City o	or Town, State Maryl	
Balt	permit. Pag Department Importent; any injury o		21. Signature of Fu	neral Service	License	n. (	sai	le		2. Name ar Peder			L L	ampto	m Fui	neral	Home,P	.A.
	Physician		23a. Fart1. Enter the shock, or heal immediate Cause disease or condition	rt failure. Lis (Final	r complic t only one	ations that cause on	each line.	e death.	Do not er	nter the mod	de of dyin	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Bety Onset and D	veen
	/Medical Examiner		resulting in death) Sequentially list co	nditions,	<b>b</b> .	Due to	( Janac	onsequer L (	Ce of):	As							147	
8760,	certificate be executed iding physician and ise as the burial-transit	ical Examiner	Sequentially list confianty, leading to many, leading to many, leading to make the cause (Disease or that initiated events resulting in death) I	}	c.	Due to	(or as a c	1 W	tin-								1 47	-
O. Box 68	death e atter ed for u	Physician/Medi	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 20 9 Unknown	months? □No	23		birth 2 [ nant at tim	Fetal de	ath 3	□Ectopic p □ Other (sp					-	23d. Date of d		'ear
ds, P.	es Be	by	Part II. Other signif	icant condit	ions cont	ributing to o	death but n	not resulti	ng in the	underlying o	cause give	en in Part i	l.		tobacco u		lo the cause of de	eath? Inknown
I Records,	The law ate has b page 2 sh	Completed													topsy rformed?	24b. Were a prior to death?		available ause of
Vital	ysicien: Th is certificate director, pag	Be (	25. Was case refer examiner?	red to medica							l ou		e of Deat	h (Check onl	y one)			
of		ion; To	1 ☐ Ýes 2 27. Manner of Deat 1 ★ Jatural	h 5 🗌 Pendi	-	28a. Date	Inpatient of Injury nth, Day Y	28	VOutpatie 3b. Time Injury		28c. Injun Worl	4 🗆 N	ursing Ho	me 5 Re 28d. Describ		S □Other (Sp y occurred	necify)	
Division	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification;	2 Accident 3 Suicide 4 Homicide	6 Could	•		e of Injury ding, etc. (		e, farm, s	treet, factor					(Street an own, State		Rural Route Numi	ber,
	ne Hospite n 24 hours ne Funere	edicai C	29a. Certifier (Check only one)			er: On the I		camination								and manner a place, and du	as stated. ue to the cause(s)	
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_			30. Name and add	ess of person	TF	npleted cau	en	MI	3a) (Type	, Print) 30-2	ed 1/1	us i	Ave	Hur 10.	ckn	rd 214	100 h	
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			For State Registrar		State	of Maryl	and /	Depa <i>Cer</i>	rtment of F	lealth a	and M		giene Reg. No.	004	3852	9
	Physicia	ın	Decedent's Name									2. Date of De Month	ath Day 13	_Year	3. Time of Death	
	/Medic	al	James :						# Ob T	.1		Nov	·	2004	2050	M
	Examin	er	4a. Facility Name (If Carroll		tal Cente				4b. City, Town, o	ninste	er.			ounty of Death Carro]	1	
	Funeral		5. Social Security N		6. Sex	7. Age (In )	yrs. last b	irthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da Dec 6	th	9. Birthp	ace (State or Foreig	
	Director		097-22-2	456	1 <b>∑</b> M 2□ F		74	Yrs.	Months Days	Hours	Min.	Dec 6	1929	Coun	NY NY	
1	and *	-	Usual Residence of 10a. State	Decedent 10b. County		10c.	. City, To	wa or Loc	eation						Od. Inside City Limit	te
A	Maryli f sho	ō	MD		rroll				ster						1⊠Yes 2∐N	
MLA	r 28a-	Director	10e. Street and Nun		TTOTT		1100	CILLI	10f. Zip Code				10g. Citizer	n of What Coun	try?	
\$	death with the Maryland rms 23a or 28a-f show rmst be notified at	a D	404 Bal	dwin P	ark Drive	Apt	A2		2115	57			U	SA		
	r dea	Funeral	11. Marital Status		Armed	cedent Ever i	n U.S.	13. W	Vas Decedent of H Yes, specify Cub	lispanic Or an, Mexica	igin? (Spe	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,		
S 8	s afte	by Fi	1 Never Marri		If Yes (	2 □ No Sive			☐ Yes 2 No					ecity: Whi		
$\omega_{CS}$ 5-0036	72 hours after naturel', or Ite	led k	o 🗆 maamaa		nt's Education	Dates.	168	a. Deced	ent's Usual Occup	oation			16b. Kind	of Business/Inc	ustry	
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^ and	buld be til Mental H arkad oth	Be	17. Father's Name (		Last)					l .		e (First, Middle, DeLuca	, Maiden Su	mame)		
Mess Maryland	2 should be and Mental is markad o	၉	19a. Informant's Na	<del></del>	ship (Tvpe, Print)		19	b. Mailin	g Address (Street		_		er City or T	own State Zin	Code) 21155	_
	s 1 and 2 should be tiled within 72 hours atter death with the Marylan f Health and Mental Hyglene. It has the marked other then "naturel", or items 23a or 28a-f show other treumetic event, the Medical Examinat must be notified at		Marie I						Baldwin						2117	/
).4	of Hez of Hez item		20a. Method of Disp	position			b. Place	of Dispos	sition (Name of latory or other pla	1		Date		tion - City or To		
) <u>E</u>	Pages ment of I ent: If its ury or o		1 ☐ Burial 21		3 □Removal from Specify)	n State C	'arro	11 C	remation	, Inc	11/	15/2004	Ham	pstead,	MD	
J.A Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.		21. Signature of Fu	neral Service	Licensee			Pr	itts fur	era1	Home	and Ch	apel,	P.A.	et at Norden un conser	
	40280		23a, P. J. Enter th	- K- T	r complications na	oguead tha a	toath Do		2 Washin					r, MD	21157 Approximate	
			snock, or hear Immediate Cause (	rt failure. List	only one cause or	each line.									Interval Between Onset and Death	
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Вох	leath certitica attending ph	Physician/Med	IF FEMALE: 23b. Was decedent			utcome of pre		h 3□	Ectopic pregnanc	v			230	. Date of delive	•	
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P.0	that the		Part II. Other signif		ons contributing to	death but not	resulting	in the un	derlying cause an	on in Part I	ı	23e Did t	nhacen use	contribute to th	e cause of death?	
Division of Vital Records,	The law requires that the death certiticate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	d by			one community to				derlying cause gi	ost iii t ait i	1.		Yes 2□1		ably 4 Junknow	m
O	s been s s should	Completed										24a. Was		4b. Were autor	sy findings availabl	le le
Re	The lav	mo										autor perfo	osy rmed? 2 <b>X</b> No	death?	pletion of cause of 2□ No	
/ita	sician: Th certificate irector, pag	BeC	25. Was case reference examiner?	red to medica								(Check only o	one)			
of \	hys this	2	1 □ Yes 2				2 DERVO		3 □ DOA Ott	ner: 4 □ Nu				Other (Specify	)	
on	the real	tion	27. Manner of Death 1 Natural	5 🗌 Pendi	ng (Mo	e of Injury onth, Day Yea	r) 280.	Time of Injury	28c. Inju Wo M 1	ryat rk?  Yes 2. □	1	28d. Describe I	now injury o	ccurred		
isi	Attending r death. actor: Atter	fica	2 Accident 3 Suicide	6 Could	not be 28e. Pla	ce of Injury - A	At home, t	arm, stre	et, factory, office	,.00 2	-			lumber or Rural	Route Number,	
ā	tal or s afte el Dire ed in t	Certification:	4  Homicide		bui	ding, etc. (Sp	ecify)					City or Tou	vn, State)			
	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely tilled in by the fu	edical	29a. Certifier (Check only one)	1 Certifyii 2 ☐ Medicel	ng Physicien: To t Exeminer: On the and ma	he best of my basis of exan inner stated.	knowledg nination a	e, death nd/or inv	occurred at the treestigation, in my	me, date ar opinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) an date and pla	d manner as sta	ated. the cause(s)	
	To t To t	Σ	29b. Signature and	→		^			29c. Licens	se number	-(-		4	igned (Month, L	Day, Year)	
	MI		P	homo		Lus I				2100	90		11114	15007		
	2		30. Name and address		**	use of death (	(Item 23a)	(Type, F	Print) RALAUBU	ue La	285	Mer et	er in	A( 11/16.	621157	
	Sta	te	31. Date filed (Mon	th, Day, Year	) 32.	Registrar's S		, 01						110 (11)	(.) /	
ř	Registr	ar		NOV 1	6 2004	Reserva	1	4	Coarte							

		1 - For State Registrar	State of Maryla			of Health and of Death		iene 004	38530
Physic /Med		Decedent's Name (First, Middle, La	JAMES				2. Date of Deat Month NOVEMBEA	Day Year 200	3. Time of Death 2:40 A M
Exami Funeral Director	ner	4a. Facility Name (If not institution, give CITIZENS NURS) 5. Social Security Number 6. S 237–20–7763	NE HOME T. Age (In y)	rs. last birthday	HAVRE If Under 1 Y	VM, or Location of Deat  DE GRACE  (ear If Under 24 Hrs  ays Hours Min.	8. Date of Birth	4c. County of Deat  HAR FC  Year)  1922 Nor	
ath with the Maryland 23a or 28a-f show wat be rutified at	ctor	-	ford 10c.	City, Town or L	Havre	de Grace			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
th with th	ai Dire	10e. Street and Number 909 Elizabet	th Street		10f. Zip Co	21078	1	0g. Citizen of What Co USA	untry?
er dez	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1943		Was Decedent If Yes, specify 1 ☐ Yes 2X	of Hispanic Origin? (S Cuban, Mexican, Puerl No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: Bl	e, etc.
215-003 thin 72 hours e. an "naturel", Medical Ext	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	DO NOT use re	one during most of wor etired)	rking	16b. Kind of Business/	
Ind 2 be filed ttal Hygi ed other	Be	8 17. Father's Name (First, Middle, Last) John James	)	Pr	operty		me (First, Middle, M	US Gover	nment
	2	19a. Informant's Name/Relationship ( Bridget Parrish )					ural Route Number,	City or Town, State, 2	
Baltimore, Mapering the permit. Pages 1 and 2 Department of Health a Importent: If them 27 is any fulury or other transpress.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	20b	. Place of Disp cemetery, cre	osition (Name of matory or other s Unite	place)	Date	Havre de G	Town, State
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licer	cett		Lisa 552 L	ddress of Facility Scott Fune ewis Stree	ral Home, t. Havre	P.A. de Grace.	MD_21078
3760, ate be executed Waterier and wysicien and he burial-transit	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a cons  Due to (or as a cons  Due to (or as a cons	CHRON equence of): equence of):	ROS	dying, such as cardiac	Correspiratory arrespiratory a	est,	Approximate Interval Between Onset and Death
O, Box 68 ne death certifica the attending pl	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	⊒Ectopic pregn ⊒ Other (specif			23d. Date of deli- Month	very Day Year
rds, P. (quires that the signed by uid be detacted		Part II. Other significant conditions of	contributing to death but not r	esulting in the (	underlying cause	e given in Part I.		acco use contribute to	\ 2
しろWのATH Vital Records, sician: The law requires t certificate has been signe	Completed							ned? death? √No 1 ☐ Yes	opsy findings available ompletion of cause of
on of Jing Phys	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c.	Othor /	ith (Check only one	nce 6 Other (Spec	ify)
Division  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not by determined	building, etc. (Spe	cify)			City or Town		
To the Hosp within 24 hou To the Fune completely fill	Medical	29a. Certifier (Check only one)  2 ☐ Medical Examone)  29b. Signature and title of certifier	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deal nation and/or in	vestigation, in r	ne time, date and place my opinion, death occu cense number	rred at the time, da	use(s) and manner as ite and place, and due od. Date signed (Month	to the cause(s)
10 + IVA		30. Name and address of person who	completed cause of death, (It	em 23a) (Type	Print)	142800	201.1	11/23/09	7
	ate trar	31. Date filed (Month, Day, Year)	3/9 S O S 32. Registrar's Sig	nature	APP.	4 140	2, May	210/8	

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State

Registrar

31. Date filed (Month, Day, Year)

NOV 2 2 2004

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Day 2004 Year **Physician** Jones 17, 2:00 P Nov. William Cary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Port Tobacco Charles 7776 Ann Harbor Dr. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-18-1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. Indiana 79 228-24-0506 Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examinat must be notified at 1 ☐Yes 2 No Director Port Tobacco MD Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7776 Ann Harbor Dr. 20677 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1943-46 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 ☐XNo by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumetic avent. College (1-4or 5+) Elementary/Secondary (0-12) Plumbing Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pearl Pauline Young Cyrus Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Eleanor T. Jones - Wife</u> 7776 Ann Harbor Dr., Port Tobacco, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens 11-22-2004 Waldorf, MD 21. Signature of Funeral Service 22. Name and Address of Facility icensee M00053 Huntt Funeral Home P.O. Box 156, Waldorf, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lung Cancon **Physician** Met4 static
Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of,. if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the at Id be detached fo ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 1 Yes 2 Z No or Attending Physicien: after death. Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 28a. Date of Injury (Month, Day Year) 27. Manner Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 □ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Hospitel within 24 hours To the Funeral Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 5291 army 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 102 CENTENNIAL STREET, LA PLATA, MD MD, JAMES HARRING, sistrar's Signature 31. Date filed (Month, Day, Year) 32. F State NOV 1 9 2004 Registrar

		1	For State State Registrar	e of Maryland / Depa <i>Cer</i>	artment of Hertificate of D			ne . Na 2 0 0 4	38533
			I. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic	al	Ruth Barton Jones				November		8:45 p M
	Examin	er '	a. Facility Name (If not institution, give street an		4b. City, Town, or l			4c. County of Dea	
			Summerville at Westmin  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Bir	thplace (State or Foreign
	Funeral Director		076-18-5045		Months Days	Hours Min.	Dec 04	1924 C	ouintry) NY
			Usual Residence of Decedent						Lod Inside City City Inside
	how		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 Serves 2 □ No
	e Ma Sa-f s	cto	MD Carroll	Westmi			100	. Citizen of What C	1.
	vith th	Dire	10e. Street and Number 45 Washington Road		10f. Zip Code 2115'	7	109	USA	oundy.
	s 23g	eral		Decedent Ever in U.S. 13.1	Was Decedent of His	panic Origin? (Sp	ecify Yes or No-	14. Race - Am	
	fter d	Funeral Director	1 Never Married 2 T Married 1 □	Yes 2 No	If Yes, specify Cuban  1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Black, Wh	
8	al', o	ρ	3 ☐ Widowed 4 ☐ Divorced Yea	s, Give r or Dates:	10 105 202400	эр <del>о</del> спу.		Specify: Wh	nite
2	72 hours after death with the Maryland 'natural', or Itams 23a or 28a-1 show dical Examinar must be multified at	Completed	15. Decedent's Education (Specify only highest grade complete	ated) (Give	dent's Usual Occupa kind of work done do DO NOT use retired)	uring most of work	ing 16	ib. Kind of Busines:	s/Industry
21215-0036	vithin han	ldm	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)	vertising			Potomac A	lmanac
2	filed v Hygie thar t	ပ္ပ	17. Father's Name (First, Middle, Last)	4 1100			e (First, Middle, Ma		
and	d be d ental	To Be	Willard Barton			Mary V	Whiting		
Maryland	s i and 2 should be filed within 72 hours after death with the Marylan If Health and Mental Hygiene. itam 27 is markad other than "natural", or Itams 23a or 28a-1 show other traumatic event. It is My dical Examinar must be mailfied at		19a. Informant's Name/Relationship (Type, Prin		ng Address (Street a	nd Number or Rui	al Route Number, (	City or Town, State,	Zip Code)
	and 2 alth a 27 is		Caroline Acker/daughte	The Contract of the Contract o	Sams Cree	4			21776
ore,	es 1 and 2 of Health fitam 27 i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	from State 20b. Place of Dispo	matory or other place	, , ,	//2004	c. Location - City o	
Baltimore,	permit. Pages 1 Department of H Important: If ita any injury or ot		* 4 ☐ Donation 5 ☐ Other (Specify)	Carrott	remation,	1		Hampstead	1, NID
3alt	Depart Import any inj		21. Signature of Functal Service License		iversan Funs				21157
	70 F # 0		23a. Part1. Enter the disease, or complications	that caused the death. Do not en	2 Washing	ton Road such as cardiac	or respiratory arres	ster, MD	21157 Approximate
			shock, or heart failure. List only one caus	on each line.	1-11		27		Interval Between Onset and Death
	Priysician /Medical		disease or condition a	ue to or as a consequence of):	whe Vo	seul	us herses	use	30gn
Г	Examiner			Lung ma	1.0				2 year
	-	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as 1/0 nsequence of):					-
	outed Id ansit	mi	that initiated events c						
o,	be executed sician and burial-transit	Exami	resulting in death) Last D	ue to (or as a consequence of):					
8760	ate be hysici the bu	edical	d						
9	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Mec	IF FEMALE: 23c. If vi	es, outcome of pregnancy				23d. Date of d	elivery
Вох	attend for us	Physician/M	in the past 12 months?	Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
o.	that the de ed by the a	nysic		Unknown					
<u>α</u>	res that igned b be deta	by Pt	Part II. Other significant conditions contributing	g to death but not resulting in the t	underlying cause give	en in Part I.	23e. Did toba		to the cause of death?
rds	w requires been sig should be						1 Yes	2 □ No 3 □ 1	Probably 4 ☐Unknown
Records,	aw re	Completed	r				24a. Was an autopsy	prior to	autopsy findings available completion of cause of
Ä		E O					perform 1 Yes 2	ed? death'	
Vital	ystcian: Th	Be (	25. Was case referred to medical examiner?		Othy		th (Check only one	No.	assisted
of V	S S	2	1 ☐ Yes 2 🕱 No	1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury 28b. Time		4 🗀 Nursing H	ome 5 Resident 28d. Describe how		pecify Zunny
		lon	1 XNatural 5 Pending	(Month, Day Year)	Work	(? Yes 2 □ No	200. 0000100 1101	injury coccinco	,
isic	Attanding r death. ector: Afte by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	. Place of Injury - At home, farm, s					Rural Route Number,
Division	Dir	Certification:	4 Homicide determined	building, etc. (Specify)	,		City or Town,	State)	
_	To tha Hospital or Attano within 24 hours after death To tha Funaral Director: completely filled in by the		29a. Certifier Certifying Physicien:	To the best of my knowledge, dea	th occurred at the tin	ne, date and place	, and due to the car	use(s) and manner	as stated.
	tha Hos hin 24 h tha Fur mpletely	Medical	(Check only 2 Medical Exeminer: Or	the basis of examination and/or identification and/or identificati	nvestigation, in my o	pinion, death occu	rred at the time, da	te and place, and d	ue to the cause(s)
	To th withir To th comp	Ž	29b. Signature and title of certifier		29c. Licenso		1	d. Date signed (Mo	
	WIL		John W Much	llita M.D	DZ.	5443		1/16/	2004
	6		30. Name and address of person who complete	ed cause of death (Item 23a) (Type	e, Print)	1 01	1, 1		1000
			John W. Mid	od cause of death (Item 23a) (Type Litton 117) 32. Registrar's Signature	488 Po.	IE Kd	Ves try	in Ster	1102113
9.0	S Regis	tate trar	31. Date filed <i>(Month, Day, Year)</i> NOV 1 6 2004	Weeces M	how.				
			1101 1 0 2001	Langua Do.	ASTAGE				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician JERRY** LEE JONES 1002 AM NOVEMBER دد 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL Hospital at Easton Talbot Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Florida 5. Social Security Number **Funeral** 1 M 2□F Days Hours Yrs. 264-10-5674 **Director** 86 Sept.4,1918 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No MD **Funeral Director** Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 312 Brooklyn Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 hand Mental Hygiene. Elementary/Secondary (0-12) 7 t h College (1-4or 5+) Transportation Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Henderson Ezekiel Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna J. Dotson/Daughter 1513 Rawlings Well Rd.. Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State njury or pernit. Page Department of Important: If any injury or Federal Hill Cem. 11/29/04 Federalsburg, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, PA 216 North Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASYSTOLE **Physician** MINUTES /Medical Due to (or as a consequence of): Examiner (ASCVD) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Ę in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) P.0. the a ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has page 2 s autopsy performed? certificate 1 ☐ Yes 2 X No 1 Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To this within 24 hours efter death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature D 005 3094 11-22-04 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Bloomingdale Ave. Federalsburg, Md. 21632 32. Registrar's Signature State Registrar

TERRY

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** NOVEMBER 7:45 DANIEL KLINE 20 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AVALON MANOR HEALTH CARE CENTER HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. Hours 1**X** M 2□ F 88 Yrs. 214-09-5580 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No HAGERSTOWN MARYLAND WASHINGTON Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 U.S.A. 14014 MARSH PIKE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 ¼Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOL HEAD MAINTENANCE ENGINEER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental F 7 Is markad of EMMA AUGUSTA CARSON CHARLES MELVIN KLINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 14738 MARSH PIKE, HAGERSTOWN, MARYLAND CLARA M. FREY/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 Other (Specify) BOONSBORO CEMETERY 11/23/04 BOONSBORO, MARYLAND neral Service Lic 22. Name and Address of Facility 21. Signature of Au 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 m cm **Physician** /Medical Due to (or as a consequence of): cerebrovasalar Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): KNS ion attending physician and for use as the burial-transit Bra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification; 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title certifier 13 1006039 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court, Hagerstown, Maryland Farid Murshed, M.D. 31. Date filed (Month Pay Year) 3 2004 32. Registrar's Signature State Registrar

				For State Registrar	State of N	Marylan		artment o			Mental Hyg	giene No. No.2	104	38536
		Physici	an	1. Decedent's Name (First, Middle, Last)  LEONA ANNETTE KIL							2. Date of Dea	Day	Year	3. Time of Death 0920 M
	3	/Medic Examir		4a. Facility Name (If not institution, give		r)		4b. City, Tov	wn, or Locati	on of Death	November		2004 ity of Death	
			Ŭ.	Memoria	1 Hes				East				albor	
		Funeral Director		5. Social Security Number 6. Sec. 1213-56-6104	7. A	Age (In yrs. I <b>52</b>	last birthday) Yrs.	If Under 1 Y Months D	ays Hou	der 24 Hrs. rs Min.	(Month, Day	7, Year) 1951	9. Birthr	place (State or Foreign Intry) DISTRICT COLUMBIA
		g.		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y. Town or Lo	cation						10d. Inside City Limits
		death with the Maryland ms 23a or 28e-f show Firsts be rudified at	lor	MD QUEEN AN	NE'S		ENSTOW							1 ☐ Yes 2 X No
		h the or 28e-	Director	10e. Street and Number		QUI	DIOLON	10f. Zip Co	ode			10g. Citizen o	f What Cou	ntry?
		ath wil	ralD	133 KILBY POINT			- 1	2165				USA		
	5-0036	n 72 hours after death with the Marylar "naturel", or items 23a or 28e-f show polical Examiner must be nutified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ▼ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force: 1 ☐ Yes 2 1 If Yes, Give Year or Date:	s? ₹No	ĺ	Was Decedent f Yes, specify			pecify Yes or No- o Rican, etc.)	Spec	ace - Americ lack, White, city: WE	
1	1215-0	12 should be filed within 72 hc h and Mental Hygiene. 7 is marked other then "netu traumatic event, It a Modical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		or 5+)	(Give life. L	dent's Usual C kind of work of DO NOT use r	doné during i retired)		king	16b. Kind of		
1/2	d 21	filed w Hygier Sther the	CO	12   17. Father's Name (First, Middle, Last)			PHAKM	ACY TE			ne (First, Middle,		IACEUT ame)	ICAL
X	altimore, Maryland 2	ges 1 and 2 should be filed withi t of Health and Mental Hygiene. If item 27 is marked other ther or other traumatic event, It a M	To Be	IRBY LAPORTE				·	CA	ROLYN	INE B. SI	EATON		
N	Man	12 sho		19a. Informant's Name/Relationship (Ty			1	127			ral Route Numbe			Code)
Aneste	ē,	ss 1 and 2 of Health item 27 i		JESSICA BATEMAN/D  20a. Method of Disposition			lace of Dispo	sition (Name on matory or other	of	VAY CH	ESTER, N	20c. Location		own, State
P	imo	Pages nent of ent: If it ury or o		1 ☐ Burial 2 X Cremation 3 ☐ P  '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from Sta	te	-			11/1	3/2004	STEVEN	SVILL	E, MD
	Balt	permit. Pages Department of t Importent: If ite any injury or of		21. Signat of Funeral Service Licent	11/6	<u></u>	F		HELI MROCK	ENBEI ROAD,			IERAL 21619	HOME, P.A.
		Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	An	SXI C	ene	er the mode o	of dying, such	has cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
		Examiner			- 1	as a conseq		tructi	r Di	Imar	ing of	ISCASI		years
		P 15	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	),	as a conseq	uence of):	·						1
		execute and at-trans	Examiner	that initiated events resulting in death) Last	Due to (or a	as a conseq	uence of):				-			
	8760,	te be e ysiciar ne burii		(	d									
į	Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta t at time of d	J death 3	Ectopic pregr Other (speci					Date of deliver	ery Day Year
	۳,	s that I pned by e deta	by Ph	Part II. Dther significant conditions co	ntributing to death	but not res	ulting in the u	nderlying caus	se giyen in P	art I.	23e. Did to	bacco use co	intribute to t	the cause of death?
	ords	equire sen sig tould b	ted t	congestive he	ert fai	Inve	Wi	10 (210	shirt 11	ntarct	Ton 1th	es 2□No	3 🗆 Prob	bably 4 □Unknown
	al Rec	: The law cate has b page 2 st	Completed	7						-	24a. Was autop perfor 1 Yes	med?	prior to co death? 1 Yes	opsy findings available ompletion of cause of
	Vita	sicien certifi irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	atient 2	ER/Outpatier	nt 3 🗆 DOA	Othor		ath (Check only o		ther /Snaci	60
	J Of	ng Phy ter this neral d	<b> </b>	27. Manner of Death  1 Natural 5 Pending	28a. Date of I		28b. Time of		. Injury at Work?	_ 14d(3)(1g 11	28d. Describe h			97
	isioi	ttendir Jeath. tor: Af the fu	icatic	2 Accident investigation 3 Suicide 6 Could not be			ama farm at-	М	1 Yes	2 🗌 No	28f Location /5	Street and Nur	mber or Bur	al Route Number,
	Divi	after after I Direct	Certification:	4 Homicide determined	28e. Place of building,	etc. (Specif	y) (y)	өөі, тасіогу, о	ITICO		City or Tow		noer or right	zi rioute riamber,
		he Hospitu n 24 hours he Funere	edical C	29a. Certifier (Check only one)  12 Certifying Phy 2 ☐ Medical Exami		s of examina								
		To the within to the comp	Σ	29b. Signature and title of certifier	1			29c. L	icense numb	19		29d. Date sign	ned (Month.	Day, Year)
<i>i</i>	•			30. Name and address of person who co	ompleted cause of	of death (Item	n 23a) (Tyne	Print)	31/	1		11/12	107	
	8	344		DAVID OLIVER 503	DUTCHMAI	NS LAN	E EAST	ON', MD	. 2160	)1				
		St Regist	ate rar	31. Date filed (Month Pey, Year) 5 2	000	istrar's Signa	die de	barle						

State of Maryland / Department of Health and Mental Hygiene Reg. NoZ U U L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2032 M November 18, 2004 Physician ADLIN MAUDE KELLY /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner rince George's Cheverly Hospi tal 6-corges rivice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | August 11,1918 | St.Mary, Jamaica 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 200 86 Director 579-78-1683 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State in than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 ☐ No Directo Maryland Prince George's Brentwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20722 USA 3900 Newton Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. **Black** þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complete College (1-4or 5+) Elementary/Secondary (0-12) Child Care Provider Private Industry 12th marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 Is marked or Theresa Neil Augustus Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3900 Newton Street 20722 Beverly Kelly-Palmer/daughter Brentwood, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Nov. 27, 2004 Brentwood, Maryland 21. Signature of Funeral Service Licensee Frazier s Funeral Home, Inc. once any. haund Watts MO132D 389 R.I. Ave., N.W. Wash., DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteroscherotic Hypertersine He Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed transit and Due to (or as a consequence of) physician a s the burial-Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day þ in the past 12 months?
1 Yes 2 XNo 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital Hospital or Attending Physicien: 26. Place of Death (Check onl one 25. Was case referred to medical Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 → R/Outpatient 3 ☐ DOA 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by 4 Homicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Bospital Sy/vsTe SALVACLN NOV 2 3 2004 32. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			_ For	artment of Health and Mental Hy rtificate of Death	giene Reg. NG 004 38538					
	Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of De	ath 3. Time of Death					
	/Medic	al	CARRIE M. KELLY  4a. Facility Name (If not institution, give street and number)	November 4b. City, Town, or Location of Death	er 17 2004 4:50 P M  4c. County of Death					
	Examin	er	Doctor's Hospital	Lanham	Prince George's					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)							
ш	Director		579-26-4549 1□M 2匁F 79 Yrs.	Months Days Hours Min. (Month, Days January	15 Maryland					
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits					
	Marylan f show	ō	MD Prince George's Lanh	am	11⊠Yes 2 ☐ No					
	r 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
	h with	a D	4412 Havelock Road	20706	U.S.A.					
	ams arren	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	)- 14. Race - American Indian, Black, White, etc.					
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show shit, the Medical Estricter out be relified a		1 Never Married 25♥ Married 1 Tyes 2 1X No	1 ☐ Yes 2 ☑ No Specify:	Specify: Black					
21215-0036	2 hou	Completed by		dent's Usual Occupation	16b. Kind of Business/Industry					
215	thin 7 e. an "n	nple.	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)						
21	ed wi ygien yar th	Cou		Clerk	Government					
Maryland	d be fill antal H and ott	) Be	17. Father's Name (First, Middle, Last)  James A. Clark	18. Mother's Name (First, Middle  Luvla Jeter	, Maiden Sumame)					
Z	should nd Me mark mark	2		ng Address (Street and Number or Rural Route Numb	er, City or Town, State, Zip Code)					
	alth ar 27 is rr trau		James W. Kelly/Husband 4412	Havelock Road Lanham, Ma	ryland 20706					
Je,	of Hei		20a. Method of Disposition 20b. Place of Disposition cometary, cre-	osition (Name of Date matory or other place)	20c. Location - City or Town, State					
Ë	Page nent c		`4 Donation 5 Other (Specify) Maryland	Veteran's 11/30/04	Cheltenham,Maryland					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23e or 28e-f show amportant: If itam 27 is marked other than "natural", or Itams 23e or 28e-f show amportant: If item 27 is marked other than 10 more. Once.			kins Funeral Home er, Maryland 20785						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. SEASIS							
	Pnysician	E 31								
	/Medical Examiner		Due to (or as a consequence of):							
	Lxammer	L.	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	·						
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of knury that initiated events c.							
Ć.	cate be executed physician and the burial-transit	Examiner	resulting in death) Last c. Due to (or as a consequence of):							
8760,	ite be iysicia ne bur	dical	d							
9	ntifica ing ph	Med	IF FEMALE:							
Box	leath certific attending p I for use as	ian/l	23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3 [	Ectopic pregnancy	23d. Date of delivery  Month Day Year					
0	the d	Physician/Me	1   Yes 2 No 9 Unknown 5   4   Pregnant at time of death 5   9   Unknown	Other (specify)						
Δ.	res that th igned by be detacl	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did	obacco use contribute to the cause of death?					
rds	w requires been sign should be	q pa	RENAL FAILURE	1 🗆	Yes 2 No 3 Probably 4 □Unknown					
Records,	law requase been 2 should	Completed	DIABETES MELLITUS	24a. Was						
		Com	HYPERTENSION	perfo	ormed? death? 2 No 1 ☐ Yes 2 No					
of Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only						
of \	Physi this c	은	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatien  27. Manner of Death 28a. Date of Injury 28b. Time of		dence 6 Other (Specify) how injury occurred					
nc	ling After fune	lon	1 Natural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at 28d. Describe Work?  M 1 ☐ Yes 2 ☐ No	now injury occurred					
Division	Attandi death. ctor: A y the fu	fical	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office 28f. Location (	Street and Number or Rural Route Number,					
Ö	al or safter	Certification:	4  Homicide determined building, etc. (Specify)	City or To	wn, State)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.							
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
			h and ms	1345217	11/18/04					
K	-5	5-3	30. Name and address of perion who completed cause of death (Item 23a) (Type, ADERUWALE AJAYI M 6201 CLES	Print) NBELT RA UIS COLLEGE AK	MD 20740					
*	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 2 2004	W						

DHMH 17 Rev 1/2001

Kelly, Carrie

			For State Registrar	State of Ma	aryland / Dep	artment of F			giene 20	04 38539
			Decedent's Name (First, Middle	, Last)				2. Date of Dea	ath	3. Time of Death
H	Physicia /Medic		Brian Hunt Le	verone				Novemb	er 22, 2	2004 8:30 A M
	Examin		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, o	or Location of Death		4c. County	
			Klein Hospice	Home		Mt. Ai				lerick
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthda) 49 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		215-62-5462 Usual Residence of Decedent		4.7			4/4/19	))	Maryland
	yiand yiand		10a. State 10b. County		10c. City, Town or I	ocation.				10d. Inside City Limits
	e-fsl	ctor	Maryland Frede	rick	Freder	ick				1★ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	ath w	ral	304 Madison A			217		2 12	USA	A. Zana Andina
96	be filed within 72 hours after death with the Maryland Hygience. A Hygience do then then "natural", or tems 23e or 28e-f show event, the Madical Examilities? As I be notified all	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 ☑ Divorced	If Yes, Give		. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No- p Rican, etc.)	Blac Specify	e - American Indian, k, White, etc.
21215-0036	hour furet	ed b	15. Decedent	Year or Dates:	16a Dec	edent's Usual Occur	pation	1	16b. Kind of Bu	White usiness/Industry
7.	in 72	Completed	(Specify only highes	t grade completed)	(Giv	e kind of work done DO NOT use retire	during most of won	king	100. 10110 01 00	omogamodotty
212	d with glene.	mo:	Elementary/Secondary (0-12)	Coilege (1-4or 5	)+)	HAV Mech	anic		Engine	ering
g	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Its Ma	Bec	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	ne (First, Middle,	Maiden Sumam	Θ)
yla	should band Ments s marked umatic e	2	LeRoy Leveron	e				n Ufhie		
, Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.		19a. Informant's Name/Relationsh		140000	ling Address (Street			amana maraka	5-605
Baltimore,			20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)		20b. Place of Disp cemetery, cri	position (Name of ematory or other pla	ce)	Date	20c. Location -	City or Town, State
alti	Departm Departm Importar any inju		21. Signature of Funeral Service		The second secon	22. Name and Addre	ess of Facility			neral Home
_	90 F # 9		Myelin	Mobel		3401 Blad	ensburg R	d; Bren	twood MI	20722
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	I the death. Do not en ne.	nter the mode of dyli	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ aMetasta	itic Head	and Neck	Carcinoma			Months
	/Medical Examiner		rosaking in south,	Due to (or as	a consequence of):					
L		er	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying	b. Due to (or as	ā consequence of).					
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	be executed ician and burial-transit		resulting in death) Last	c. Due to (or as	a consequence of):					
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9	requires that the death certificate een signed by the attending phys nould be detached for use as the		IF FEMALE:							
Box	eath certific attending p for use as 1	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc	у		23d. Date Mor	e of delivery hth Day Year
-	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _				,
P.0	that the da ed by the detached		Part II. Other significant condition	ens contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use contr	ribute to the cause of death?
Records,	w requires that been signed is should be det	d by	Cancer Cachex	ia				101	res 2□No	3 Probably 4 □Unknown
COI	> 9 8	Completed						24a. Was	an 24b. V	Vere autopsy findings available
Re	The age	ошо							rmed? d	prior to completion of cause of leath? Yes 2 Ro
Vital	icien: T	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only o	Λ	Yes 2 No
Į <	8 8 5	To B	examiner? 1 ☐ Yes 2 ☐ <del>x</del> No	Hospital: 1   Inpatie	ent 2 ER/Outpatie	ent 3 DOA Ott	ner: 4 🙀 Nursing H	ome 5 Resid	dence 6 Othe	er (Specify)
n of	ding Phy h. After thi funeral o		27. Manner of Death  1 Natural 5 Pendin	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury	of 28c. Inju	ry at rk?	28d. Describe h	now injury occurre	be
sio	Attending r death. ector: After by the funer	catl	2 Accident investig	gation			Yes 2 □ No			
Division		Certification;	4 Homicide determ		ury - At home, farm, s c. <i>(Specily)</i>	treet, factory, office		City or Tow		er or Rural Route Number,
_	Hospital		29a, Certifier 1 X Certifyin	g Physician: To the best	of my knowledge, dea	ith occurred at the ti	me, date and place	and due to the	cause(s) and mai	nner as stated.
	To the Hospital or within 24 hours after To the Funerel Discompletely filled in	Medical		Examiner: On the basis of and manner sta	examination and/or i					
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			_	(Month, Day, Year)
•			MA-2-+	+CGAZII	MO	D44	164		11/22/2	004
A	5		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type	Print)				
14		-	A. Z. Hegazi	46 B T	homas John	nson Driv	e; Freder	ick MD 2	21702	
	Sta Registi		31. Date filed (Month, Day, Year)	3 ZUU4 32. Hegistr	ar's Signature	grand .				

		-	State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death	-	giene Reg. No. 0 0 L	38540
			Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physici	_	John Marshall Lynch Sr.	Novemb	er 16 2004	11:45 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of C		4c. County of Deat	
	LAGITIII	C1	Prince George's Hospital Cheverly		Prince G	eorge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24			hplace (State or Foreign
	Director		245-52-7858   1 1 1 2   F   67   Yrs.   Months   Days   Hours   1	Min. (Month, Da April 4		th Carolina
	р ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	-		40d Inside City Limite
	show	_				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8a-f	Director				
	tiled within 72 hours after death with the Maryland Hygiene. uthar then "natural", or Items 23a or 28a-f show with the Madical Examinar must be notified at		106. Street and Number 10f. Zip Code 20785		10g. Citizen of What Co	ountry?
	s 23	by Funerai	ZZO4 Matthew Henden IIVenee	2 (Specify Voc. or No		nican Indian
	Item Item	Ë	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No	Puerto Rican, etc.)	Black, White	
36	Ir, or	by F	If Yes, Give 1 ☐ Yes 2₺ No Specify: 3₺ Widowed 4 ☐ Divorced Year or Dates:		Specify:	lack
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/	
215	hin 7.	Completed	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  (Give kind of work done during most of life. DO NOT use retired)	f working		
21,	d with giene ar the	mo:	12th Heavy Equipment Ope	rator	Private	
	e file al Hy otha vant,	Be		Name (First, Middle	, Maiden Surname)	
<u> a</u>	uld b Ments rrkad ific a	To	John Lynch Daise	ey Lee	Moore	
Maryland	12 should be filed within "h and Mental Hygiene." 7 is marked other then "rraumatic avant, the Med		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of	or Rural Route Numb	er, City or Town, State, I	Zip Code)
	and salth n 27		Beverly L. Carter/Daughter 1462 Capitol View Te	*		
ore	of He		20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)  20b. Place of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City or	Town, State
Ĕ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Importants if item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at ange.		`4 □Donation 5 □Other (Specify) Riverdale Crematory   1.		Riverdale,	-
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	J. B. Jen	kins Funera	1 Home
<u> </u>	89 = 9		K. D. Manhall 7474 Landover Ro	ad Landov	er, Marylan	d 20785
			23a. Part1. Enter the diserce, or complications that bused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	rrest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):		, ,	1
	Examiner	,	Sequentially list conditions, b. Right Tempons periotif	Hempr	hogee 51	who wind
	p #	ine	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)  A C C C C C C C C C C C C C C C C C C	1 11	/	2
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a-consequence of);	nont H.	y per ensu	LUAYS
50,	cate be executed oblysician and the burial-transit	Ē	Hy per tens con		1	year:
8760	cate t	dicai	d			
9 ×	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		2015	
Вох	attend for us	lan	in the past 12 months?		23d. Date of del Month	Day Year
-	the a	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown			
P.0.	that t	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
ds,	sign d be	d by	Non-insular Dependent DM	1 🗆 '	Yes 2 No 3 Pr	obably 4 ∐Unknown
Records,	w require been sig should b	Completed by	Es Cl H to	24a. Was	an Jah Wara si	tanau findings qualible
3ec	has has	mpl	Listen Rd (14porten) on	autor		topsy findings available completion of cause of
a	ician: The lav certificate has ector, page 2		Kenal Insuffered	1 ☐ Yes	2 No 1 □ Yes	25 No
Vital	ysician: is certific director,	Be	examiner? Other	Death (Check only of		
of	Phys rthis ral di	. To	1 Yes 2 No riospital. 1 Inpatient 2 ER/Outpatient 3 DOA Outer. 4 Nursii  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (Spectors)	cify)
on	ding h. After fune	tion	1 Natural 5 Pending (Month, Day Year) Injury Work?		,.,	
Division of	Attan deat ctor: y the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office		Street and Number or Ru	ıral Route Number,
D	after Dire	erti	4 Homicide building, etc. (Specify)	City or To	wn, State)	
-	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	aic	29a. Certifier 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and p	place, and due to the	cause(s) and manner as	stated.
	a Ho 24 h a Fui letely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death one) and manner stated.	occurred at the time,	date and place, and due	to the cause(s)
	To th withir Fo th compl	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Monti	h, Day, Year)
			1/ Michael Ter 200528	265	November	17th 2004
in	~ 3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		· OVEF	do -
N	2		Michael Figaro M.D. 3001 Hospital Drive Chever	ly, Maryla	and 20785	
	Sta	te	31. Date filed (Month, Day, Year)			
	Regist		NOV 2 2 2004 Marker & America			

State of Maryland / Department of Health and Mental Hygiene. Reg. No. U U L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RACHEL R. LACEY NOVEMBER 18 2004 12:44A /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1929 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 SF Months Days Hours Min 75 230-42-2076 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1X Yes 2 No Directo Prince Georges Upper Marlboro MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or U.S.A. 20772 Funeral 16913 Dirchester Place death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 \*natural', or 1 Yes 2 No ģ Specify: 3 ₩ Widowed 4 Divorced **Black** Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Private Supervisor permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic svent SDRs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P George Neal Frances Sharps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ricardo C. Lacey/Son 1841 Saratoga Court Yuba City, Calif. 95993 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation demoval from State \* 4 □ Donation 5 □ Other (specify) 11/23/04 Harwood, Maryland Church Cemetery 21 Signature of Funeral Jep to Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small cell Lung **Physician** cancer Zmmhe /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions dary, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼ Yes 2 □ No 24a. Was an certificate has t autopsy performed 1 Yes 2 No or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: ၉ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation ours after death.

nerel Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29c. License number · Karner by D35206 November 19,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livington Rood Fort WASHington monyland TANNER, UM William T. 31. Date filed (Month, Day, Year) State NOV 2 2 2004 Registrar

			State of Maryland / Department of Health and Mental Hygie  1- State Registrar 1]-30-04 Amend#15. Per FH RC cr Certificate of Death Reg. A Relation Reg.	7 H H D 3 X X X D 7
*	Physici		1. Decedent's Name (First, Middle, Last)	Day Year 3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  LAUREL  5. Social Security Number  6. Sex  1 M 2XF  7. Age (In yrs. last birthday)  Wonths Days Hours Min.  8. Date of Birth (Month, Day, Yes.)  Months Days Hours Min.  3 5 1	4c. County of Death  AN NE ARUHOXL  9. Birthplace (State or Foreign Country)
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  LAYREL	10d. Inside City Limits
	h with the	al Director		Citizen of What Country?
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jinal Examiner must be mailfied al	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0	within ane. than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  However	b. Kind of Business/Industry  OWN HOME
Maryland 2	should be filed nd Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mail	DENHER NAHRA
, Mar	d 2 h a 7 is		19a. Informant's Name/Relationship (Type, Print)  NICK D, MERZA  19b. Mailing Address (Street and Number or Rural Route Number, Cr. 8013 BIG Pock DR., LAU	
Baltimore	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		1 XBurial 2 Cremation 3 Removal from State COLUMD A GARDES 11/24/04 F	
Bal	Depar Depar Impor any ir		21. Sinalure Funeral Service Licitsee  22. Name and Address of Facility, WERAL HOM  MURPHY FUNERAL HOM	
	Physician		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and d for use as the burial transit	lical Examiner	Sequentially list conditions, I say backing to him soluble cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	years
O. Box 6	the death certifici y the attending pl ched for use as t	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown	23d. Dale of delivery Month Day Year
rds, P	law requires that the de as been signed by the a 2 should be detached i	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacc	co use contribute to the cause of death?
Vital Records,	The ate h page	Completed	Pulmonary Embolism  Deep Vonous Thombus.  24a. Was an autopsy performed 1 yes 2	
of	ding Phys	ation; To Be	25. Was case referred to medical examiner?  1	
Division	Diffe in Diffe	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, St.	t and Number or Rural Route Number, tate)
	Hoo Fur Fur	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of the cause	e(s) and manner as stated. and place, and due to the cause(s)
(1	othin to the comple	W		Date signed (Month, Day, Year) - 21 - 2004
H	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 VAN DUSCN ANGELA DUNCAN	1 ROAD, #130
	Sta Registr	6	31. Date filed (Month, Day, Year)  NOV 2 3 2004  32 Registrar's Signature	

		1. Decedent's Name (First, Middle, Last)			sittineate of		2. Date of De			3. Time of Death
Physic /Medi		John M	Natthei	US			Month	O S	<b>0</b> 4	10:00P
Exami		4a. Facility Name (If not institution, give s	street and number)			or Location of Dear	th		ounty of Death	trunde
Funeral Director		5. Social Security Number 6. Security Number 17 17 17 18 19 17 18 19 19 19 19 19 19 19 19 19 19 19 19 19	7. Age (	(In yrs. last birthday	y) If Under 1 Year Months Days		(Month, Da	iy, Year)	Coui	place (State or Forei ntry) H CAROLIN
2 3		Usual Residence of Decedent  10a, State 10b. County		IOc. City, Town or I	Location				1.	10d. Inside City Limi
nous allel locali will lite malyland turel, or items 23a or 28a-1 show al Exsolicer must be notified at	ō	MD QUEEN ANY		GRASONVI						1 ☐ Yes 2 🔀
128a	Funeral Director	10e. Street and Number	NE D	GIGIDOIIVI	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
238.0	a D	113 PERRY CORNER I	ROAD		21638			USA		
ems BLD	iner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	. Was Decedent of I	Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No to Rican, etc.)	)- 1·	4. Race - Americ Black, White,	
iene. r than "natural", or items 23a or 28a-f show tre Medical Examinat must be notified at	b	1 Never Married 2 Married 3 Widowed 4 Divorced	1 <b>T</b> Yes 2 ☐ No If Yes, Give Year or Dates:	UNK.	1 ☐ Yes 2 X No					HITE
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	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Car	d Shop	Owner		Rei	tail	
d other	Be C	17. Father's Name (First, Middle, Last)			•	18. Mother's Na	me (First, Middle	, Maiden S	Sumame)	
	70 6	JACOB EDWARDS MATT	THEWS			NANCIE	HILL			
th and 7 is m traum	1 8	19a. Informant's Name/Relationship (Ty FRANCIS ALLEN MAT)	_		WATER EDG				·	Code)
I a 5		20a. Method of Disposition	TILLIO, ILLI	20b. Place of Disg	position (Name of	1 55	Date		ation - City or To	
0		1 Mag Burial 2 □ Cremation 3 □ F  1 □ Donation 3 □ Other (Specify)	Removal from State		ematory or other pla	1	2/2004	WASH	INGTON,	NC
Department important: bany injury o		21. Signal are of Furrerat Service License	Le M	F	22. Name and Addre ELLOWS, E 06 SHAMRO	ess of Facility	N & NEWN	IAM FU		
		shock, or heart failure. List only or	ne causé on each line.	ne death. Do not e	nter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	21619	Approximate Interval Between
Medical xaminer portion and prize transit	cal Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. Disease of thury	Due to (or as a of Due to (or a)	ration consequence of):	P mu	ing, such as cardia	c or respiratory a	rrest,	71819	Interval Between
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death filed within 72 hours after other than

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:00 P M MARIE LOUISE MCCORMICK NOVEMBER 6, 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEARTLAND HOUSE GRASONVILLE OUEEN ANNE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F Yrs. 214-42-1732 96 Director OCT. 24, 1908 MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County r than "natural", or itams 23a or 28a-f ehow the Medical Exercises must be notified at 1 ☐ Yes 2 YNo QUEEN ANNE'S MD STEVENSVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 LOVE POINT ROAD 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE Specify: þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSE MEDICAL permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other eny liquy or other traumatic event, 906. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JAMES W. KEMP MARY E. BROADBENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 LOVE POINT ROAD, STEVENSVILLE, MD JANE CHAMBERS/DAUGHTER 20b. Place of Disposition (Name of cometery, crematory or other place)

NEW CATHEDRAL Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) 11/10/2004 BALTIMORE, MD CEMETERY 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 13 106 SHAMROCK ROAD, CHESTER, MD 21619 Port . Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of) Examiner 6 mo. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and I for use as the buriat-transit 6 ma as a consequence of) Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Yes peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 2 1 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ŧ 2 1 Yes 2 No 3 DOA After this funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No nours after death neral Director: / filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled i 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 027055 Name and address of person who completed cause of death (Item 23a) (Type, Print) MODICAL CONTON Rd, GRASONVILLE Md 21638 KERSON

DHMH 17 Rev 1/2001

State Registrar 1061

31. Date filed (Month, Day, Year)

1 M D

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nov. 16, 2004 **Physician** Blanche McGarrh 8:45 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Lutheran Home Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 8, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 506-01-1546 1 □ M 2√□ F 88 Nebráska Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at Md. Montgomery Rockville 1 X Yes 2 □ No Director 10e. Street and Number 9701-Veirs Dr. 10g. Citizen of What Country? 10f. Zip Code 20850 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give 1944 Year or Dates: 1944 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Violin Teacher 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is markad oth any injury or other traumatic event sone. Be James Erca Carrie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rev.Dr. Reichard-Executor 9701--Veirs Dr., Rockville, Md. 20850 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arlington Nat.Cem, 12/3/2004Arlington, Va. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Hysong Co., Inc. 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as a macro we flatory and a process on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAL DYSRRHYTHNIAS /Medical Due to (or as a consequence of): Examiner HEART FAILURE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner led by the attending physician and detached for use as the burial-transit To tha Hospital or Attanding Physician: The law requires that the death certificate be execufed HYPERTEN SION Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical TLEUS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š ate has been sign page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yas rs after deau...
ral Director: After this ceru... 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 47 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🖫 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To tha Funeral Directo completely filled in by the 4 Momicide HT Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NOVEMBER 16 2004 Wherele Bully D0051158 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 NO 208 50 9701 VEIRS DRIVE ROCKUILLE VATTIT. ANTHONY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** November Lois M. Murphy 17,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elkton Union Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F PA 82 Director 214-14-8301 July 21,1922 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show If a Medical Exercit er must be notified at 1 Yes 2 No Director Ceci1 Elkton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21921 76 Hollingsworth Manor U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Americen Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ XSo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry jes 1 and 2 should be filed within 7 of Health and Mental Hygiene. If itam 27 Is marked other than "r or other traumatic avant, If a Med Elementary/Secondary (0-12) College (1-4or 5+) 11 Machine Operator W.L. Gore Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amanda S. Wileman James Cooper Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 76 Hollingsworth Manor, George Murphy/husband Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I ant: If its 1 Burial 2 Cremation 3 Removal from State November 22,2004 permit. Page Department of Important: If any injury or once. Elkton Cemetery ` 4 ☐ Donation 5 ☐ Other (Specify) Elkton, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or cord, lications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death 2 days MD Immediate Cause (Final STROKE **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY 3 ☐ Probably 4 ☐ Unknown 1 TYes 2 □No Completed been HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To tha Funaral Director: / 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 1 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 18, 2004 D0051197 Mayeus person who compteted cause of death (Item 23a) (Type, Print) Ugth STREET , # 320 WILMINGTON , DE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

2004

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division of Vital Records,

AN			1 - For State Registrar	State of Maryland /	Department of Health and Certificate of Death	Mental Hygier	711114 20CL 7
	Physici /Medio Examin	cal	Decedent's Name (First, Middle, Las JEFFREY PLATER  4a. Facility Name (If not institution, give	SR. street and number)	4b. City, Town, or Location of Deat	November	2004 Year 3. Time of Death 3. Time of Death 4c. County of Death
	Funeral Director		Prince Georges Ho 5. Social Security Number 213-56-6561  Usual Residence of Decedent		Cheverly If Under 1 Year I If Under 24 Hrs Yrs. Months Days Hours Min.		Prince Georges  9. Birthplace (State or Foreign Country)  Maryland
	the Maryland 28e-f show	ector	10a. State 10b. County	George s 10c. City, To	wn or Location  Lanham  10f. Zip Code	100	10d. Inside City Limits 1X Yes 2 □ No Citizen of What Country?
36	be filed within 72 hours after death with the Maryland tal Hygiene. A other than "netural", or items 23a or 28e-f show of other than "netural", or item and the notilised at event. The Madical Examination must be notilised at	by Funeral Director	8929 Glenarden Pa	12. Was Decedent Ever in U.S. Armed Forces? 1	20706  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland 21215-0036	filed within 72 hour Hygiene. Ither than "netural ent, tre Medical Ex	Completed by	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation 16 de completed)  College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NDT use retired)  Pest Control	rking 16b.	Kind of Business/Industry  Private
<b>laryland</b>	ss 1 and 2 should of Health and Men item 27 is marke other treumatic	To Be (	17. Father's Name (First, Middle, Last)  Jesse Plata  19a. Informant's Name/Relationship (7)		18. Mother's Nar  Gurtrud  3b. Mailing Address (Street and Number or Ru  929 Glenarden Pkwy La	ral Route Number, City	v or Town, State, Zip Code)
Baltimore, N			Olettia Plater/Will 20a. Method of Disposition 1 Seurial 2 Cremation 3 1 '4 Donation 5 Streetly	20b. Place cemet	of Disposition (Name of ery, crematory or other place)  rrection Cemetery 11	Date 20c.	Location - City or Town, State inton, Maryland
Balt	permit. Page Department of Importent: If any injury or ang injury or		21. Signature of Fundal Sorvice Licens 23a. Part 1. Enter the disease, or sempshock, or heart failure. List only of		22. Name and Address of Facility J.  7474 Landover Road onot enter the mode of dying, such as cardiac	Landovr, 1	s Funeral Home Maryland 20785 Approximate Interval Between
	ate be executed // Medical Examiner in purish transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Atheroscleration  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  d.	Cardiovaxulan		Onset and Death
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death?
Vital Records,	The ate h page	Completed	Obesity			24a. Was an autopsy performed? 1 X Yes 2 N	
of	ling Phye	tlon: To Be	25. Was case referred to medical examiner?  1 Nayes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	6 □Other (Specify)			
Division	Atten deat ctor: y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or within 24 hours after To the Funerel Dire completely filled in b	Medical	(Check only one) 2XXIII edical Exam	sician: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place ind/or investigation, in my opinion, death occu	rred at the time, date a	nd place, and due to the cause(s)
)	or with		29b. Signature and title of certifier  M.  30. Name and address of person who c	m . D	O.C.M.E.		vente signed (Month, Day, Year) venter 17, 2004
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	111 Penn Street, Ba	ltimore, Ma	aryland 21201

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 38548 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Berta Maria Parker November 17, 2004 7:15 p.m. /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 14580 Triadelphia Mill Road Dayton Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Yrs 75 27, 1929 Director 216-22-9843 Feb. Maryland Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified a 1 ☐ Yes 2 ☐ No Directo Maryland Howard Dayton 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? ŏ 238 14580 Triadelphia Mill Road 21036 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be file iment of Haaith and Mentel Hant: If item 27 is marked oth Jury or other traumatic even Conrad John Heimbach Marie Frisch 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14580 Triadelphia Mill Road Dayton, MD 21036 Ryan J. Parker/husband 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 18, 2004 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Povely L. Heckrotte, P.A. C

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medical a Adenocarcinoma of Lung Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificete be executed burial-trensit physician and s the burial-tren Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): After this certificate hes been signed by the attending p funeral director, page 2 should be detached for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed TUYes at No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Yeer) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNaturel 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director; Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigetion 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) end manner es stated. (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 1 Con MO D17821 November 18, 2004 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Warren M. Ross M.D. 4801 Dorsey Hall Drive #201 Ellicott City, MD 21042 32. Registrer's Signeture 31. Date filed (Month, Day, Year) State

**DHMH 16 Rev 6/95** 

Registra

NOV 19

2004

State of Maryland / Department of Health and Mental Hygierie 0 0 4 38549 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MICHELE JANE PIERSON NOV. 18, 2004 12:16P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1525 E MAIN ST., CARROLL HAMPSTEAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F 59 219-44-7748 Director 10/16/1945 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir then "naturel", or Items 23a or 28a-f show The Medical Examiner must be notified at MD. 1X Yes 2 □ No CARROLL HAMPSTEAD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1525 E MAIN ST. 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Date♥ IETNAM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Item eny injury or other traumatic event, the Medical Exp. directions. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 4 HOUSEWIFE HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) THOMAS EARL PIERSON ANNA MARGARET GIESER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 VALLEY VISTA CT., MANCHESTER, MD.21102 DON M. PISARSKI - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Tormation 3 Removal from State ALL COUNTY CREMATION 11/19/04 SYKESVILLE, MD. Final Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME ignati 254 E. MAIN ST., WESTMINSTER, MD. 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleant failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Years granomysopalu disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury Due to (or as a consequence of) Examine the attending physician and thed for use as the burial-transit equires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2-No 1 ☐ Yes 1 ☐ Yes 2 ☐ 1√0 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 3 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 291 Stores Avenue CHACKO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Blew & Sparke Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year 6:50PM November 22 /Medical Leo Edward Riffle 12004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs. <u>Washington</u> **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct.31,1915 Birthplace (State or Foreign Country) 1**XX**M 2□F Months Days Hours Director 89 Maryland 214-10-4008 the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show other treumetic event, the Madical Examiner must be notified at Director 1 ☐Yes 2 No Washington Maryland Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e 16332 Lappans Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes Y No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 3/7 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo þ Specify. 3 ☐ Widowed 4 ☐ Divorced "neturel", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Leo Riffle Bessie Vanzulia Lyday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Comer - Daughter 4319 Mountville Road Jefferson, Maryland 21755 20a. Method of Disposition
XXBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Importent: If eny injury or 1 4 ☐ Donation → ☐ Other (Specify) Greenlawn Mem. Park Nov.26,2004 Williamsport, Maryland 21. Signa e of Funeral Service OSborned PuneralityHome, P.A. 425 S. Conococheague St. Williamsport, Maryland Approximate Interval Betwee Organ and De 23a. Part1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certiticate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed to Part I. Piner significant conditions contrib 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 \( \text{No} \) No certiticate Division of Vital 2 🗓 1□ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) P 1 Him atient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 NO 2 ER/Outpatient 3 DOA After th tuneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide hin 24 hours a 1 — ertifying Physicia.: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Maminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature 0 29c. License number d cause of death (Item 23a) (Type, Print) 16 ZNE 32. Segistrar's Signature 31. Date filed (Mor State Registrar

		1 - For State Registrar		epartment of Certificate of		Reg. No	2111111 2	8551
Physici /Medic	cal	Decedent's Name (First, Middle, Lasi     Sarah May Rowe     Aa. Facility Name (If not institution, give		4b. City. Town	or Location of Death	2. Date of Death Month Da		58 PM
Examir Funeral	ier	Washington County 5. Social Security Number 6. Se	Hospital x 7. Age (In yrs. last birtho	Hager	stown	8. Date of Birth	ashington	State or Foreign
Director		218-30-8702  Usual Residence of Decedent  10a. State  10b. County	M 2₹⊈F 86 Yr.			October 14, 1	918   Ohio	
vith the Marylan or 28e-f show be notified at	Director	MD Washingt	on Hagersto	OWN 10f. Zip Code		10g. Cit		ide City Limits  ☐Yes 2X No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentalle Hydiene.  The contract of the Azi is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, The Medical Examinat must be notified at once.	by Funeral	13725 Pennsylvania  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced		2174  13. Was Decedent of If Yes, specify Cu  1 □ Yes 2 ☑ No	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	A  14. Race - American Ind Black, White, etc.  Specify: White	ian,
d within 72 ho giene. or than "natur	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 10 th	(College (1-4or 5+)	ecedent's Usual Occu live kind of work doni e. DO NOT use retir nemaker	upation e during most of worki ed)	ng	ind of Business/Industry Home	
in yland, in hould be file in Mental Hygumarked other matic event,	To Be C	17. Father's Name (First, Middle, Last)  Frank Jeremiah I.  19a. Informant's Name/Relationship (7)	ong		Mary Me	elissa Jone	Sumame)	
Pages 1 and 2 s Pages 1 and 2 s not of Health ar not: if item 27 is rry or other trau		Mary F. Sprankle / 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ F	Daughter 1372		vania Ave.	Hagerstow	n, MD 21742 ecation - City or Town, St	
permit. Pa Deportmen Important: any injury		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		on Mem. Pa 22. Name and Addr 305 N. Po	ress of Facility Ger	7/2004 Har Cald N. Min Hagerstown	erstown, MD nich Funera . MD 21740	l Home
Physician /Medical		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not ne cause on each line.				Appro	eximate al Between and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence(of):  Due to (or as a consequence of):	Jail Ven	luce bropatt	Q.	88	gr_
cate be executed physician and the burial-transit	dicai	that initiated events resulting in death) Last	Due to (or as a consequence of):			0		
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnanc 5 □ Other (specify) _	су		23d. Date of delivery Month Day	Year
w requires that been signed t	by	Part II. Other significant conditions con	ntributing to death but not resulting in the	e underlying cause gi	iven in Part I.	23e. Did tobacco u	se contribute to the caus	
	Completed	Ear	may filery	Diseas	)	24a. Was an autopsy performed?	24b. Were autopsy find prior to completion death? 1 \square Yes 2 \square No	n of cause of
Phys this	on: To Be	25. Was case referred to medical examiner?  1   Yes   2   Mo   1  27. Manner of Death 1   Natural   5   Pending	ospital: 1 Impatient 2 ER/Outpa  28a. Date of Injury (Month, Day Year) Injur	of 28c. Inju		(Check only one) ne 5 □ Residence 6 28d. Describe how injury		
Atten er deat ector: by the	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1	Yes 2 □ No	18f. Location (Street and City or Town, State)	d Number or Rural Route	Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medicai (	29a. Certifier (Check only one)  2 Medical Exemi	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	investigation, in my	opinion, death occurre	ad at the time date and	place, and due to the ear	use(s)
P ≥ P 8		30. Name and address of person who co	Inspired cause of death (Item 23a) (Tyr	pa. Print)	7898	290. Date	e signed (Month, Day, Ye 23/04 Mn 2174	ar)
5ta	to	PKAN CISCO A	PDRADE 350 32 Aegistrar's Signature	MILL ST	· HAGER	25 TOWN	Mn 2174	9

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Nov. 18, 2004 Year **Physician** Edna P. Rosenfield 1735 /Medical 4c. County of Death
Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hosp. Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Sept. 19,1919 | Virginia 5. Social Security Number 215-36-4607 7. Age (In yrs. last birthday) 85 Yrs. 6. Sex **Funeral** 1 ☐ M 2 💢 F Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location Rockville Md . 10d. Inside City Limits or 28e-f ehow other traumatic event, the Medical Examiner must be notified at Montgomery Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 9701-Veirs Drive USA Itams 23a death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglena. Important: If item 27 le markad other than "natural", or Itan any injury or other traumatic event, Ita Medicul Examana. 2008. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ervilla Short Russell Lee Painter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701-Veirs Dr., Rockville, Md. 20850 Milton Rosenfield-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Beams Chapel Cem. 11/23/04 Luray, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Hysong Co. W. m. 6510-16th St., NW, Wash., DC 23a. Part1. Enter the disease shock, or heart failure. I Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in each line. Immediate Cause (Final Physician Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter the control of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death cartificate be executed nding physician and usa as the burial-transit Dementia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Wo Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? Yes 2 No 1 Yes To the Hospital or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Xnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 20 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 24 hours 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) within 2 9b. Signature and title of 29d. Date signed (Month, Day, Year) certifier 29c. License number 9 1)006168 11 60 and address of person who completed cause of death (Item 23a) (Type, Print) Shady Grove Adventist Hospital, Rockville, Md. Day 2 2 nth. State Registrar

		4	For State Registrar	State of Maryland	•	rtment of		lental Hygie	2004	38553
		No.	Decedent's Name (First, Middle, Last)					2. Date of Death Month	_DayYear	3. Time of Death
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	- Ks - *		Citizens Nursing		a de de instructor (1)	If Under 1 Ye	rederick	8. Date of Birth	O Birth	place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 1 N	7. Age (In yrs. la 4. 2 12 15 89	Yrs.	Months Da		Mar. 26	5. 1915 Con	intry) MD
			Usual Residence of Decedent							
	how		10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 25€No
	8a-f	Director	MD Freder	CICK	Fred	erick		100	. Citizen of What Co	
	with the		10e. Street and Number 231 N. Market S	2+		10f. Zip Cod	21701	1,09	USA	,
	ns 23	Funeral		. Was Decedent Ever in U.S	S.   13. \		of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f ahow imatic event, it a Medicial Examina marke indifficial and imatic event.	by Fun	1 Never Married 2 Married 3 Widowed 4 ODivorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify 0 1 ☐ Yes 2 🔀		Hican, etc.)	Specify: Wh	
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ře,	T 1 6 -		20a. Method of Disposition	CE CE	emetery, crer	sition (Name o	place)		c. Location - City or	
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Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Si nature of Funeral Service Licemee		3	31 E.	B. Thomp Main St.,	Middle	town. MD	21769
153	*		23a, Part . Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not ent	er the mode of	dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
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H	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):					O
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× ×	Physician: rthis certificant	2	1 ☐ Yes 2.25(No		ER/Outpatie			ome 5 Residen	ce 6 Other (Spe	cify)
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Division of Vital Records,	l or Attending after death. Diractor: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specification)	ome, farm, st			28f. Location (Stre City or Town,	reet and Number or Rural Route Number, , State)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical Ce	(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina	wledge, dea	th occurred at to	he time, date and place my opinion, death occu	, and due to the cau	use(s) and manner as e and place, and due	s stated. e to the cause(s)
one) and manner stated.  4 sign of the control of t						th, Day, Year)				
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•			30. Name and address of person who con	mpleted cause of death (Item	п 23а) (Туре		() (0 0 1	1.1.	7,9	
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3	St Regis	tate trar	31. Date filed (Month, Day, Year) NOV 1 9 20	32. Registrar's Signa	ature &	do	als)			

State of Maryland / Department of Health and Mental Hygiene 0 0 4 38554 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ETHEL M. REINEKING 7 AM 2004 November 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Smailtospitalof baltimore BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 2√2 F 147-18-8736 Director 5/20/1923 NEW YORK Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No CARROLL WESTMINSTER MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 420 RIDGE RD. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2X No 1 ☐ Yes 2X No Specify: Specify: WHITE ð 3X Widowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry WESTERN ELECTRIC Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR 12 FUND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fand Mental M THOMAS McAvoy Elizabeth Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If itam 27 is: ury or other trau 418 RIDGE RD., WESTMINSTER, MD. 21157 KAREN MISERANDINO -SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ⊁□ Burial 2 XCremation 3 □Removal from State permit. Page Department o Important: If any Injury or once. ALL COUNTY CREMATION 11/17/04 SYKESVILLE, MD. Donation 5 Other (Specify) Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician peritoneal cancer 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day ō 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown nernia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2**)**(1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2√2 No 2 nours after death. neral Diractor: After this filled in by the funeral d 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29b. Signature and title of certifier November 16,2004 MJC 12ES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedera Ave Bultimore mend inD sinai itospital of Baltimore

State Registrar 31. Date filed (Month, Day, Year)

NOV 17

2004

Reinering, Ethe

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Elsen & Spell

32. Registrar's Signature

			For State Registrar	State of Mar		artment of				ene 001	38555
	Physici	_	1. Decedent's Name (First, Middle, Las						2. Date of Death Month	Day Ye	3. Time of Death
A STATE OF THE STA	/Medio Examin		Dolores Jane Smi 4a. Facility Name (If not institution, give	street and number)		4b. City, Town		of Death	Novemb	4c. County of [	Oeath
	Funeral		Clearview Nurs 5. Social Security Number 6. Se		(In yrs. last birthday			24 Hrs. Min.	8. Date of Birth (Month, Day,	Year) 9.	ngton County Birthplace (State or Foreign Country)
	Director		204-26-4039  Usual Residence of Decedent  10a. State 10b. County		7.2 113.	ocation			Jan 4 1	932	Pennsylvania  10d. Inside City Limits
	should be filed within 72 hours after deeth with the Maryland of Mental Hygene. marked other than "natural", or Itama 23a or 28a-f show maric event, the Modical Examinar mout be notified at	Director	Maryland Washin		Hagers	town					1 ☐ Yes 2 ☑ No
	with the		10e. Street and Number 9946 Downsville	Diko		10f. Zip Cod			10	g. Citizen of Wha	
	ms 23	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Yes, specify C		igin? (Spe	cify Yes or No-		American Indian,
396	irs after of ital	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify C			lican, etc.)	Specify:	<sup>Vhite, etc.</sup> White
15-0036	n 72 hou "nature	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Giv	edent's Usual Oct s kind of work do DO NOT use ret	cupation ne during mos	st of workin	ng 1	6b. Kind of Busin	ess/Industry
12121	filed withii Hygiene. other then ent, the M		Elementary/Secondary (0-12) 12	College (1-4or 5+)		memaker					Residence
Maryland	uld be fil Mental H irked ott	To Be	17. Father's Name (First, Middle, Last) Melvin Houck						(First, Middle, M Jensen		
lar)	2 should I and Men is marke		19a. Informant's Name/Relationship (7)							City or Town, Sta	
	s 1 and 2 should if Health and Men Item 27 is marke other traumatic		Cindy J. Kellinge  20a. Method of Disposition	r	190 20b. Place of Disp	and the state of t				Maryland Oc. Location - City	
٥	0 0		1 Donation 5 ☐ Other (Specify		cemetery, cre	matory or other p n Cemete	olace)			undalk,	
altimore,	그 돈 본 등 .		21. Signature of Juneral Service Licens								uenral Home
ñ	Depa Impo any I		Laniel C	· Yauley							aryland 21742
)/1	Fnysician /Medical		23a. Part . Enter the disease, or comp shock, or heart failure. List only of transdate Cause (Final disease or condition resulting in death)	a.	mz 1				respiratory arres		Approximate Interval Batween Onset and Death
	Examiner				consequence of):						
	pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
,092	death certificate be executed eathending physicien and ider use as the burial-transit	ai Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						
687	ificate g physi as the l	edical		a							
.O. Box	he death certific r the attending p ched for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□ Unknown	☐Fetal death 3	⊒Ectopic pregna ⊒ Other (specify)				23d. Date of Month	delivery Day Year
s, P.	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions co	ontributing to death but	not resulting in the	underlying cause	given in Part I	l.	23e. Did toba	acco use contribut	e to the cause of death?
rds	w requires been sign should be	ed b	Dietitis mo	Milis 1	espector	nelin			1 🗆 Yes	s 2 □ No 3 □	Probably 4 Hunknown
Vital Record	elaw hast je2s	Completed				<del></del>			24a. Was an autopsy perform	ed? prior	e autopsy findings available to completion of cause of n? Yes 2 \sum No
<u>ra</u>	Physiclan: Th this certificate ral director, pag	Bec	25. Was case referred to medical examiner?						(Check only one	)	
<u>&gt;</u>	Physiclan: rthis certific ral director,	ဍ	1 ☐ Yes 2 ☐ No		2 ER/Outpatie					nce 6 Other (5	Specify)
S	ding After fune	tlon:	27. Manner of Death  1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day )	(ear) 28b. Time (	٧	ljury at Vork? □ Yes 2 □		8d. Describe hov	v injury occurred	
Division of	i or Attending after death. Director: After in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, si (Specify)				8f. Location (Stre City or Town,		r Rural Route Number,
	spital	edical Ce		ysician: To the best of iner: On the basis of e and manner state	xamination and/or in						
	To the Ho within 24 h To the Fu completely	Me	29b. Signature and title of certifier			29c. Lice	ense number			d. Date signed (M	
			- Conti	MO		D	8018	ì		~ = V ( 9	, 2004
5	4-2	-	30. Name and address of person who d	completed cause of dea	th (Item 23a) (Type	Print)	· hA	LER	5-10W-	u mo	21740
- 8.5	Sta Registr		30. Name and address of person who could be a second of the second of th	004 32. Rigistrar	s Signature	berle					

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** LEONORA SUROSKY NOVEMBER 9, 2004 6:00 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year It Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) 9. Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1921 OF COLUMBIA 1 □ M 2 🗙 F Director 83 JULY 11, 577-28-5088 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other treumatic event, the Medical Expresser result to motified at 1 Yes 2 No Director **OUEEN ANNE'S QUEENSTOWN** MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 21658 833 STAGWELL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Btack, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Etementary/Secondary (0-12) Coltege (1-4or 5+) 12 U.S. GOVERNMENT SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Pages 1 and 2 should be SAMUEL RABOY ANNA SICKLE ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 i CAROL JELICH/DAUGHTER 833 STAGWELL ROAD, QUEENSTOWN, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Buriat 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 11/10/2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY STREET, CENTREVILLE, MD 21617 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Corchavagular atenoscherosis 6W **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year signed by the at d be detached fo 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2000 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown Completed Deen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? s certificete ha 1 ☐ Yes 2500 the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ij this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Matural 5 Pendina 1 Tes 2 No investigation i Director: d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed, (Month, Dey, Year) 0 37036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ariu Chiste, MD 2004 Register's Signature 31. Date filed (Month, Day Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician**  $\mathbf{P}^\mathsf{M}$ 11, 2004 NOVEMBER 9:12 ROBERT ALLEN STARR, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL ANNAPULLS

If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)

OCT. 28, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 61 Yrs. **NEW JERSEY** 1943 Director 175-34-8335 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location wode 10a. State notified at 1 Yes 2 No Director ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö ust be 1930 SEVERN GROVE ROAD 21401 USA 238 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status the Medical Examiner filed within 72 hours after 1 ☐ Never Married 2 X Married 1 MaYes 2 □ No If Yes, Give Year or Dates: -Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **EXECUTIVE** MEDICAL 12 4 Ith and Mental Hygie 27 is marked other I renmatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be MARY BOSSLE ROBERT ALLEN STARR, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANCY SMITH STARR/WIFE thent of Health 1930 SEVERN GROVE ROAD, ANNAPOLIS, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 5 Importent: any injury c CHESAPEAKE CREMATORY 11/16/2004 STEVENSVILLE, MD ' 4 Donation 5 Other (Specify) 21. Signal e de Funeral Service Licensee nd Address of Facility
S, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician Myocardia /Medical Due to (or as a consequence of) Examiner ancreati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the o 9 Unknown 9 Unknown signed by Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown 1 🗌 Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No certificate 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 VInpatient 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Certification: Injury 1 Natural 5 Pending 1 Yes 2 No investigation death. I Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours after To the Funerel Dire 29a. Certifier 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 851C npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 9 M 2001 MEDICAL PKWY, ANNAPOLIS, MD 32. Regittrar's Signature 31. Date filed (Mont) State 5 Registrar

**ORIGINAL** 

			For	State of Marylan	d / Depa	artment of I	Health and		ene	00000
			1 - For State Registrar		Cei	tificate of	Death		3. No2 U U 4	
	Physicia	an	Decedent's Name (First, Middle, Last)  Lula	Simmons				2. Date of Death Month	r 14 2004	3. Time of Death  10:30P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea		4c. County of Dea	
	Examin	E	St. Thomas More	·		-	Hyattsvi			e George's
	Funeral		5. Social Security Number 6. Sec			If Under 1 Year Months Days	If Under 24 Hr	s. 8. Date of Birth		thplace (State or Foreign
L.	Director		3/9-26-2229	M 201F 8	35 Yrs.			Dec. 16,	1918 No	rth Carolina
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary I sh	tor	Maryland Prince	George's		Hvat	tsville			1 XYes 2 □ No
	or 288	Directo	10e. Street and Number	ocorgo o		10f. Zip Code	COVIIIC	109	g. Citizen of What Co	ountry?
	23a c		4922 LaSalle R	d.			20782		United	States
	er de: Itams	Funerai		12. Was Decedent Ever in U. Amed Forces?	.S. 13. \	Was Decedent of f Yes, specify Cub	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, Whit	
50	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1□Yes 2√∏ No	Specify:		Specify: P	lack
21215-003b	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, It a Medical Evantmer must be rediffied at once.	ted	A 15. Decedent's Edu	cation	16a. Deced	ient's Usual Occu	pation	16	Bb. Kind of Business	/Industry
N	thin 7 e. an n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	life. l	DO NOT use retire	during most of word)	orking		
N	ed wi ygien ner th 1, the	Con	12th			House	keeper		Private	<u> </u>
yland	be fill hall Hall He out	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle, Ma		
Ĕ	should be find Mental I	ဥ	James Dair  19a. Informant's Name/Relationship (Ty		19h Mailin	on Address (Stree	t and Number or F	Lula M. Rural Route Number, (	(Unknown)	Zin Code)
Z Z	ith an		Mary E. Gilmore					Rd., N.W.	-	
ค์	s 1 ar f Hea itam other		20a. Method of Disposition	20b. P		sition (Name of natory or other pla			c. Location - City or	
saltimore,	Page nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State			Park 11/	22/2004	Landove	er. MD
<u>a</u>	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	P		. Name and Addr	ACT OF THE PARTY O	Stewart Fu		
n	20 E 20		John T. S	leway, III	- 11			d., N.E. W		20019
	į		shock, or heart failure. List only or	ications that caused the death ne cause on each line.	h. Do not ent	er the mode of dy	ing, such as cardia	ac or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease of condition resulting in death)	1,		ic Cardi	ovascu1a	r Disease		Years
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Š,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
09/89	death certificate be executed e attending physician and id for use as the burial-transit	dical		d	_					
o X O	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	Incv				1	
0	atten for us	cian	in the past 12 months?	1 Live birth 2 Fetal	Ideath 3	Ectopic pregnand Other (specify)	у		23d. Date of del Month	Day Year
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Z.	law requires that the de as been signed by the a 2 should be detached	by Pi	Part II. Other significant conditions con			nderlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
cords	en sig			ral Infarctio				1 ☐ Yes	2 XNo 3 □ Pr	obably 4 Unknown
ပ္	S S	Completed	Alzhe	imer's Diseas	е			24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
	The said	Соп						performe	d? death?	2□ No
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:				eath (Check only one)		
0	hys this al di	. To	1 ☐ Yes 2X No	1   Inpatient 2	ER/Outpatien 28b. Time of	t 3 DOA	4 Nursing	Home 5 Residence		cify)
SION	the ne	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork? ]Yes 2 □ No	20d. Describe flow	injury occurred	
<u>s</u>	ial or Attandii s after death. al Diractor: Al ad in by the fu	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, str				et and Number or Ru	ural Route Number,
5	s afte	Certification;	4  Homicide determined	building, etc. (Specify	V)			City or Town,	State)	
	To the Hospital or At within 24 hours after of To the Funaral Dirac completely filled in by	edical (	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my kno- nar: On the basis of examinat	wledge, death	occurred at the ti	ime, date and plac	e, and due to the cau	se(s) and manner as	stated.
	the hin 24 the F	Medi	onej	and manner stated.						
	S S S	_	29b. Signature and title of certifier	100 1			DO1252		Date signed (Mont)	
			30. Name and address of person who co	umpleted cause of doath (the	23a) (Time		D01352		November	10, 2004
K	9C		Paul A. DeVo				d., Hyat	tsville, M	D 20781	
	Sta	te	31, Date filed (Month, Day, Year) NOV 2 2 2004	32. Registrar's Signa	ture					
	Registr	ar	HUY & Z ZUUT	we to the						

		-	pe or Print				•	•	ble.
	-	For State Registrar	state of Mary		tificate of			gierie Reg. No	
Physicia		Decedent's Name (First, Middle, Last)     LESTER LEE SMITH	-				2. Date of Dea Month いついった	ath Day	Tip Pary
/Medic Examin		4a. Facility Name (If not institution, give stre		tal	4b. City, Town, o	r Location of Death	1	Potal	of Death
Funeral Director		220 70 5615	7. Age (In	yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da MAY 02,	y, Year)	Birthplace (State or Foreign Country)     MARYLAND
/land		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation		-		10d. Inside City Limits
death with the Maryland ms 23e or 28a-f show rmust be notilited at	Director	MARYLAND PRINCE GE	ORGES	SEAT PLEA	SANT				XX Yes 2 □ No
with th	Dire	10e. Street and Number	uma potuc		10f. Zip Code	/2 1722		10g. Citizen of W	
ns 23e	Funeral	6028 JEFFERSON HEIG	Was Decedent Eve	r in U.S. 13. \		43-1733	pecify Yes or No		O STATES  - American Indian,
urs after al', or Ite	þ	THE MENTER OF THE PROPERTY OF	Armed Forces?  1 ☐ Yes XX No If Yes, Give Year or Dates:	ŀ	f Yes, specify Cuba 1 ☐ Yes XX No	lispanic Origin? (S an, Mexican, Puerl Specify:	o Rican, etc.)		k, White, etc. BLACK
"natural",	letec	15. Decedent's Educati (Specify only highest grade co	on ompleted)	(Give	dent's Usual Occup kind of work done OO NOT use retired	during most of wor	rking	16b. Kind of Bu	siness/Industry
is 1 and 2 should be filed within 7 is 1 and 2 should be filed within 7 if firem 27 is marked other than "n other traumatic event, the Mod	Completed	Elementary/Secondary (0-12) 1 2 TH	College (1-4or 5+)		ENANCE W			GOVE	RNMENT
be filed ital Hygid d other event, i	Be	17. Father's Name (First, Middle, Last)						Maiden Sumam	Θ)
should and Men marke umatic	င္	HORACE SELLMAN  19a. Informant's Name/Relationship (Type,	Print	10h Mailie	Address (Ctrast	HAZEL S	-	City of Town	State Tip Code)
and 2 s ealth an n 27 Is r			THER		-	and Number or Ru ON TERRA			ILL, MD 20745
of Hea		20a. Method of Disposition 1 □ Burial XX Cremation 3 □ Rem	2	20b. Place of Dispo		1	Date		City or Town, State
Pages tment of tent: If it jury or o	,	* 4 □ Donation 5 □ Other (Specify)		ETROPOLIT					NDRIA, VA
permit. Pages Department of Himportent: If ite eny injury or of any injury or of ange.		21. Signature of Funeral Service Licensee	Ill	MA /4.3	Name and Addre	ss of Facility FUNERAL AND ROAD	HOME OF	MARYLAN AND, MD	ND, INC.
		23a. Part1. Enjer the disease, or complicat shock, wheart failure. List only one of	ions that caused the						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Diabe	1	elli tus				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):			-		
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	onsequence of):					
executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Durate (see a se					<u>-</u>	
_ @ _	_		Due to (or as a co	onsequence or):					
tificate ig phys as the	ledic	d							
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of p  1 Live birth 2   4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	<b>y</b>		23d. Date Mor	e of delivery hth Day Year
w requires that the been signed by should be detact	by	Part II. Other significant conditions contrib Renul FAI		ot resulting in the ur	nderlying cause giv	en in Part I.			ibute to the cause of death?  3 Probably 4 Unknown
The law reate has bee	Completed						24a. Was autop perfor	rmed? p	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	nital:		0.11		ith (Check only o	ne)	
Phys this al dii	. To	1. Yes 2 No Hosi	1 🗀 Inpatient	2 ER/Outpatien 28b. Time of		4 🗆 Nursing n		dence 6 Othe	1 7 77
Attending Ph r death. ector: After th by the funeral	atlor	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury	Wor	rk? Yes 2 □No		,,	
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	At home, farm, stre	eet, factory, office		28f. Location (5 City or Tox		er or Rural Route Number,
ne Hospi ne Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Exeminer	en: To the best of m : On the basis of exa and manner stated	amination and/or inv	occurred at the tirvestigation, in my o	me, date and place opinion, death occu	, and due to the orred at the time,	cause(s) and mar date and place, a	nner as stated. Indidue to the cause(s)
To tl within To tl	M	29b. Signature and title of certifier	2 Post	محر	29c. Licens				(Month, Day, Year)
2		30. Name and address of person who comp		Hospit fa	Print) R Drom	e che	verli.	MAN	19 2004 11920
Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	eli)	,	J		
Registr	3	NOV 2 2 2004	July 1	No Mayor				<del></del>	

DHMH 17 Rev 1/2001

Registrar

NOV 2 2 2004

		1	For State Registrar	State of Maryland /	Depa <i>Cer</i>	rtment of Health a	and Men	tal Hygie	ene2004	38561
			Decedent's Name (First, Middle, Last	nt)				ate of Death		3. Time of Death
	Physicia /Medic		Marguerite Iris	Smith			1	wonth vember		12:36 a™
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Location of	of Death		4c. County of Death	
			Anne Arundel Med			Annapolis	04 Uss		Anne Arun	
п	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last b □ M 2፟ F 90	Yrs.	Months Days Hours		Date of Birth Month, Day, Y b. 16,	(ear) 9. Birthi Coul. 1914 Wash	place (State or Foreign ptry)
	Director		577-34-2527 Usual Residence of Decedent				10	0. 10,	1914 Wasii	ingcon, bo
	yland		10a. State 10b. County	10c. City, Tov	wn or Lo	cation				10d. Inside City Limits
	B-18	cto	Maryland Anne Ar	undel Mayo						1 ☐ Yes 2 No
	or 28	Oire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
	ath w	Funeral Director	214 Cadle Avenue	40 Was Danidat Sussia II C	10.1	21106	ining (Consider		S.A.	can Indian
	ter de Item	nue.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No		Vas Decedent of Hispanic Orig f Yes, specify Cuban, Mexican	n, Puerto Rica	n, etc.)	Black, White,	
39	al', or	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 2 No Specify:			Specify: Whi	.te
ŏ	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show the Mcdical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		a. Deced	lent's Usual Occupation kind of work done during most	t of working	16	6b. Kind of Business/In	dustry
2	ithin 19.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)				
7	led w lygier har th		17. Father's Name (First, Middle, Last)		omema		ar's Name (Fir		Wn Home	
altimore, Maryland 21215-0036	ntal Hed of	Be								
Ž	should be fi and Mental H a marked of umatic evai	၉	Cyril H. Collett  19a. Informant's Name/Relationship (	Type, Print) 19	b. Mailin	g Address (Street and Number		. Fraz ute Number, (		Code)
Z	ulth ar 127 la r trau		Trudy L. Hettenho	Daughter	214 (	Cadle Avenue.	PO Box	481	Mavo, Marv	land 21106
ē,	ss 1 and 2. of Health ar itam 27 la		20a. Method of Disposition	20b. Place	of Disno	sition (Name of natory or other place)	Date		Oc. Location - City or T	
E	Page nent o int: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State			1/22/2	004 W	ashin ton,	D.C.
ä	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiene. Important: If item 27 is marked a other than "natural; or Items 23a or 28a-1 show Important: If item 27 is marked other than "natural; or Items 29 and 27 is marked other than "natural; or Items 27 is marked at any injury or other traumatic event, the Macdical Examiner must be notified at anone.	1	21. Signature of Edneral Service Licer	1500		. Name and Address of Facilit				
<u></u>	99 = 9	10 1	//alnull	May 110137		739 Baltimore				
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	o not ent	er the mode of dying, such as	cardiac or res	spiratory arres	it,	Approximate Interval Between Onset and Death
k	Prysician	ar a	Immediate Cause (Final disease or condition resulting in death)	a. Asperation	Ph	reumanica			1	3 WKS
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):					
		-i-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	e of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C						
o,	an an		resulting in death) Last	Due to (or as a consequence	e of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical		d						
9	entifica ling pl e as t	Med	IF FEMALE:	On House subsequent					1	
Вох	eath certific attending p for use as t	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
Ö	는 도 등	ysic	1 ☐ Yes 21 No 9 ☐ Unknown	9 Unknown	5	Cuter (specify)				
٣.		by Ph	Part II. Other significant conditions	contributing to death but not resulting	in the u	nderlying cause given in Part I	l.	23e. Did toba	cco use contribute to t	he cause of death?
rds	requires een sign nould be	q pa	Pontine Drift	rct				1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown
000	> 0 0	ompieted						24a. Was an autopsy	24b. Were auto	opsy findings available empletion of cause of
Ä	o -c o	E						performe	ed? death? No 1 ☐ Yes	·
ital	iclan: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?					neck only one		
of Vital Records,	Phyaiclan: this certificated ral director,	၉	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C					ce 6 Other (Speci	(y)
n c		ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	. Time o Injury	f 28c. Injury at Work? M 1 ☐ Yes 2 ☐		Describe now	vinjury occurred	
Division	C # 5 0	icat	2 Accident investigatio 3 Suicide 6 Could not b	28e. Place of Injury - At home.	farm, str		28f.	Location (Stre	eet and Number or Rur	al Route Number,
Di≤	after Direct	Certification:	4 Homicide determined	building, etc. (Specify)	,			City or Town,	State)	
	Hospital 4 hours a Funaral I tely filled			nysician: To the best of my knowled						
	n 24 I he Fu pletely	edical	(Check only 2 Medical Examone)	miner: On the basis of examination a and manner stated.	and/or in	vestigation, in my opinion, dea	ath occurred a			
	To the Hospital or Atta within 24 hours after de To the Funaral Directo completely filled in by th	Σ	29b. Signature and title of certifier			29c. License number			<ol> <li>Date signed (Month,</li> </ol>	
•	./		Man	D. Juban,	MO		63	1	lownuber 17	, 2004
	A 4	0	30. Name and address of person who	174 000 10 1111	1 00	Print) West Rive	· MI	) 20	778	
	Sta	ate	31 Date filed (Month, Day, Year)	32. Registrar's Signature		)	,		1 7 V	
		rar	NOV 2 2 2004	Me de	1					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended#23perMD FCHD,KS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year 1 Ś Anthony November 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 523 Gateway Drive, West Thurmont Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1⊠M 2□F Days Director 165-18-7323 84 Jan. 8, 1920 Pennsylvania Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location If itam 27 Is marked other than "natural", or Itams 23a or 28a-f show or other traumatic svant, the Medical Examinar must be mailtied at 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 523 Gateway Drive, West 21788 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Family Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Toth Anna Uhrin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline P. Toth / Wife 523 Gateway Drive, West Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State November 18 2004 permit. Page Department of Important: If any injury or once. Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22 Name and Address of Facility Stauffer Funeral Homes, P.A. 04 E. Main Street Thurmont, Maryland 21788 21. Signar re of Juneral-Service Licensee 104 E. Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Physician months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Cther (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Tes 2 No 3 ☐ Probably 4 ₩Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 1 🗆 Yes 2 🗀 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 - Nursing Home 2 1 □ Yes 2 🗖 🗤 0 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A 00 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registra

			For State	State of N	laryland.		artment of H		and Mer		iene	104	38563
			Registrar  1. Decedent's Name (First, Middle)	, Last)			timouto or i	Dodan		Date of Deat	h	0 7	3. Time of Death
	Physici /Medic		Catherine	Victori		1er				Month 11.	- 18-2		22:20 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution,	-	r)		4b. City, Town, or					unty of Deat	
L.			Southern MD I		han //n /n./	a de landa este esta	C L i	nton If Under 2		- ( D' t)			eorges
п	Funeral Director		5. Social Security Number  5.79 – 4.0 – 3.1.6.4  Usual Residence of Decedent	6. Sex 1 □ M 2X F	Age (In yrs. last 86		Months Days	Hours	Min.	Date of Birth (Month, Day, 0 – 0 3 –	Year)	Co	hplace (State or Foreign untry) yland
	pun *		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	ecation						10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or itams 23a or 28a-1 show uth, the Medical Evanirar must be retified an	tor		Georges			Suitla	nd					1 ∑Yes 2 ☐ No
	r 28a	Funeral Director	10e. Street and Number				10f. Zip Code	nu.		1	0g. Citizen	of What Co	untry?
	h with	<u>=</u>	5132 Clacton	Ave.			20	746				USA	
	deat	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	13.	Was Decedent of H	lispanic Orig	gin? (Specify	Yes or No-		Race - Ame Black, White	rican Indian,
36	s after	by Fu	1 Never Married 2 Marrie 3 2 Widowed 4 Divorced	ed 1 Tes 2 If Yes, Give	No	1	1 ☐ Yes 21X No			,,			lack
8	hour tural	ed b	15. Decedent	Year or Dates		6a. Dece	dent's Usual Occup	ation			16b. Kind o	of Business/	Industry
215-0036	hin 72	plet	(Specify only highes Elementary/Secondary (0-12)			(Give	kind of work done of DO NOT use retired	during most d)	of working				
21	ed wit	Completed	12			1000	l Servic					vern	ment
Maryland	d be filk ental Hy ked oth c evan	To Be	17. Father's Name (First, Middle, L Richard	Dorsey				18. Mothe	r's Name <i>(Fi</i> V Es	rst, Middle, l tella		name) OWN	
ary	shour and M s mar umati	-	19a. Informant's Name/Relationsh	nip (Type, Print)			ng Address (Street						
	and 2 saith a n 27 is		Deborah Graha	am/ Daught	- e i		Clacton	Ave					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic evant, the Medical Evantment or notified at once.		20a. Method of Disposition  1 反 Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.		cem	etery, crei	osition (Name of matory or other place		Date			on - City or	
ij	artme artme ortan injury		21. Signature of Funeral Service (		Res	urre	ction C 2. Name and Addres	em. 1	v Tavl	or's	Fune	ral	Home
B	permi Depar impo any ir		1/3.6	Jayla	N	1			-				. DC 20002
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caus	ed the death. I								Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	a.	Pneu								Onset and Death  7 Week
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9	ding p	/Me	IF FEMALE:	23c. If yes, outcon	ne of oregnancy	,					024	Date of deli	None (
Box	death of atten	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal de at time of deati	ath 3[	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	′			230.	Month	Day Year
P.O.	that the de led by the a detached t	hysi	9 Unknown	9□ Unknown									
	es De de	by P	Part II. Other significant condition	ns contributing to death	but not resultir	ng in the u	nderlying cause giv	en in Part I.					the cause of death?
Records,	w requir been si should	Completed								<del>.</del>	s 2□N	0 3 PR	obably 4 ∏Unknown
3ec	has by	mpl								24a. Was a autops perforr	y	4b. Were au prior to d death?	topsy findings available completion of cause of
<u>a</u>			25. Was case referred to medical	3				00 BI	10 11 10	1 Yes 2	<b>∑</b> No		2 No
Vital	Physician: this certifica ral director, p	To Be	examiner?	Hospital: 1 ☑Inpa	itient 2 TER	VOutpatier	nt 3 DOA Oth	OF:	of Death (C)			Other (Snec	n(fix)
of	<u>a</u> = <u>a</u>		27. Manner of Death	28a. Date of Ir		Bb. Time o				Describe ho			ny)
jor	Attending Probability of the funer of the fu	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation		,		Yes 2 1	Vo				
Division	i or Att after de Diract	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined 286. Place of	Injury - At home etc. (Specify)	e, farm, sti	reet, factory, office		28f.	Location (St City or Town		umber or Ru	ral Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director; completely filled in by the	Medical C	29a. Certifier   Certifyin (Check only one)	g Physicien: To the be Examiner: On the basis and manner	of examination	dge, deat and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, and th occurred a	due to the ca	ause(s) and ate and pla	manner as	stated. to the cause(s)
	To the within 2 To tha complet	Med	29b. Signature and title of certifier		-,utod.	······	29c. Licens	e number		2	9d. Date sig	gned (Month	n, Day, Year)
	/ /		m. Side	av				453	65		11-	19 - 2	2006/
Ť	\$ 3		30. Name and address of person of the Sid		f death (Item 23	Ba) (Type,	Print) Flor	RJ.	# 101.	f+ u	Ashi	ng Ton	n. Day, Year) Donk/ MD Do749
F	√ Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	9	111/		1"/	, -		<i></i>	
	Regist	rar	NOV 2 2 2	2004	a K	1	A.						

State of Maryland / Department of Health and Mental Hygie 2e 0 14 38564

			1 - For State Amend #26, p  1. Decedent's Name (First, Middle, La:		11/18/	Wilicate of	Death	2. Date of Dea	eg. No.		3. Time of I	Death
	Physici		MABEL			Novembe	r <sup>Day</sup> l, 2	.ď <sub>0</sub> 4	10:50	Рм		
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Location of Death			4c. County	of Deeth		
			Kline Hospice Hou	se		Mt. Aiı			Carro			
ı	Funeral Director		212-03-3073	ex 7. Age (In y	rs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 10	Year)		plece (State or ntry) y Land	Foreign
001	ne Maryland 8a-f show	ector	Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederi	_	City, Town or Lo	stown					10d. Inside City	
	h with th	al Dire	10e. Street and Number 12434 Creagersto	wn Road		10f. Zip Code 2178	38	,	0g. Citizen of V	S.A.	ntry?	
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene . marked other than "rstural", or items 23a or 28a-f show martic event, the Medical Examinar man the molified at	by Funeral Directo	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of half Yes, specify Cub	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		k, White,	can Indian, etc. ite	
5	72 ho	eted	15. Decedent's E	ducation de completed)	(Give	dent's Usual Occup	during most of wor	rking	16b. Kind of Bu	siness/In	dustry	
7	should be filed within nd Mental Hygiene. marked other than * imatic event, the Ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT u</i> se retire omemaker	d)		Own	Home		
2	buld be filed w Mental Hygier arked other tl atic event, the	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Nar	ne (First, Middle,	Maiden Surnam	ne)		
ylalla	Menta	To	John.Remsburg				Edna Wa					
<u>8</u>	nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship ( Kenneth L. Wastle			ng Address <i>(Street</i> Wheat Mil						
more,	permit. Pages 1 and 2 should Department of Health and Men Important; if item 27 is marke any injury or other traumatic ance.		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □  ↑ 4 □ Donation 5 □ Other (Special	JEGINOVALINOIN SIAIG		osition (Name of matory or other pla Cemetery	ce) 11/1	4.	20c. Location - reagers	•		Land
Daillinor	permit. Pag Department Important; any injury o		21. Signature of Further Service Lea	Deley	Rổi 61	Name and Addre BERT E. I 5 EAST MA	DAILEY &	SON, FUNE	RAL HOM	ES, 788	P.A.	
	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused he done cause on each line.	earn. Do not ent	er the mode of dyill	ng, such as cardia	or respiratory arr	est,		Approximate Interval Betw Onset and D	reen
	/Medical Examiner			Due to (or as a cons	sequence of):							
	and I-transit	Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cons								
09/00,	rificate be executed by physician and as the burial-transit	ledical E		. d								
O. BOX	death cer e attendir rd for use	Physician/Mo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 2 ☐ F	to the state of t					e of deliv	_	ear .
ras, r	requires that the	by	Part II. Other significant conditions of	contributing to death but not clearly contributing to death but not contributions that the contributions are the contributions to the contributions are th		nderlying cause gr	ven in Part I.		bacco use contres 2 No		he cause of de bably 4 🗆 U	
al Record	The lay ate has page 2	Completed	Diasi	tes, Type				24a. Was a autops perfor 1 Yes	med?	Were auto prior to co death?	opsy findings a impletion of ca 2 PNo	vailable use of
vital	Physician; this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Ott		ath (Check only or	-	Н	osp <u>i</u> ce	
on or	Physrathis rald	-	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time o	f 28c. Inju Wo	ner: 4 Nursing h	28d. Describe h		er <i>(Specii</i> red	y Hous	se
DIVISION	I or Attending after death. Director: After I in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	e 200 Bloom of Injury A	At home, farm, str ecify)			28f. Location (S. City or Town		er or Rur	al Route Numb	oer,
-	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, deat sination and/or in	h occurred at the trivestigation, in my o	me, date and place opinion, death occu	a, and due to the curred at the time, d	ause(s) and ma ate and place,	inner as s and due t	stated. o the cause(s)	
	To the within 2 To the Complete	Me	29b. Signature and title of certifier	Becken		29c. Licens			9d. Date rigner			
	5		30. Name and a sess of person to B 2 D 31. Date filed (Month, Day, Year)	completed cause of eath (	Nem 23a) (Type,	Print) Water	st. 7	TURMON	T.m.D.	21	788	
ì	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	5 100	ake					

			For State	State of Maryland / Dep	ertificate of Death	Mental Hygien Reg. พ	4004 38353
			Registrar  1. Decedent's Name (First, Middle, Las			2. Date of Death	3. Time of Death
	Physicia	an	LEWIS PIERCE WALL			Month Di	ay 13.2004 10:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat		c. County of Death
	Examin	eı	Manakin	Magor	Princess Anne	mo	Somerset
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthday		8. Date of Birth	9. Birthplace (State or Foreign
	Director		220-12-2450	XIM 2□F 91 Yrs.	Month's Days Hours With	January 11,	1913 Maryland
3	2		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation		10d. Inside City Limits
-	ehov det	_					1 <b>½</b> Yes 2 □ No
3	89-1	ecto	MD Worceste	r Pocomoke	10f. Zip Code	100.0	Citizen of What Country?
1	De C	ā		1	21851	109.0	USA
-	s 23	era	824 Second Stree			pecify Yes or No-	14. Race - American Indian,
9	s 1 and 2 should be lied within 72 hours alter deam with the waryand if Health and Mental Hygiene. If Health and Mental Hygiene. It is marked other then "neturel; or items 23a or 28a-1 ehow other treumatic event, the Mactical Examiner must be multified at	by Funeral Director	1 Never Married  Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White, etc.  Specify:
3	turei ILE	edt	15. Decedent's Ed	ducation 16a. Dec	edent's Usual Occupation	16b.	White Kind of Business/Industry
2	2/ ul eu" r	Completed	(Specify only highest gra	ade completed) (Giv	e kind of work done during most of wo DO NOT use retired)	rking	
	iene.	E o	Elementary/Secondary (0-12)	College (1-4or 5+) Mai	ntenance	Foo	nd Processing
3	othe ont,	as l	17. Father's Name (First, Middle, Last)	)	18. Mother's Na	ne (First, Middle, Maide	n Sumame)
	Mental	To B	John Wesley Wa	tson	Viola	Mae Lewis	<u> </u>
<u> </u>	should Ind Ment	<b>-</b>	19a. Informant's Name/Relationship (		ling Address (Street and Number or Ri		
Ě	l and 2 lealth a lm 27 is her tre		Naomi Elizabeth		Second St., Pocom	oke City, M	D 21851
֝֞֝֞֝֝֞֝֞֝֓֞֝֟֝֞֝֟֝֞֝֟֝֟֝ <del>֡</del>	of Head		20a. Method of Disposition Burial 2 Cremation 3	20b. Place of Disp cemetery, cri	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State
]	Page nent c		'4 □Donation 5 □ Other (Specif		ist Cemetery 11/	7/04 Po	comoke City, MD
	permit. Pages I Department of H Importent: If ite any injury or ot once.	Ш	21. Signature of Funeral Service Licer		22. Name and Address of Facility Fu	neral Home,	P.A.
٥	8858		Muchael 1.	Delin 1	03 Linden Ave. P	ocomoke Cit	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not e	nter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	P	HSWI		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):			
	Examiner		Sequentially list conditions,	b			
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	cate be executed physician and the burial-transit	Cam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):			
Š	oe ex cian a ourial		1000111119 111 111111	Due to (or as a consequence or).			
0/0	cate c	dicai	•	d			
9	ding p	Me	IF FEMALE:	23c. If yes, outcome of pregnancy		I	23d. Date of delivery
ַבְּיבְיבָ מַבְּיבְיבָ	death certific e attending pl d for use as t	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
	the shed	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	Cities (Specify)		
Ŀ	that the second	モ	Part II. Dther significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
'n.	requires that the een signed by th hould be detache					1 🗀 Yes	2 No 3 Probably 4 Unknown
5	- Q 10	ete				24a. Was an	24b. Were autopsy findings available
niosau	ela has je 2	Completed				autopsy performed?	prior to completion of cause of death?
- '	icien: The certificate hi rector, page			1	00 Bloom of Do	1 Yes 2 N	No 1 Yes 2 No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	04	ath (Check only one)  Home 5 - Residence	6 FlOther (Specify)
5	Phys rthis raldii	5	27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how inj	
5	ding Ph h. After th funeral	ţ	1 □Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
DIVISION	or Attending ufter death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At home, farm,	street, factory, office	28f. Location (Street	and Number or Rural Route Number,
Ś	ol or Atteno after death Director: d in by the t	Certification:	4  Homicide	building, etc. (Specify)		City or Town, Sta	,te)
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in D			hysician: To the best of my knowledge, de			
	n 24 l n 24 l ne Fu	Medical	(Check only 2 Medical Examone)	miner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	urred at the time, date a	no place, and due to the cause(s)
	To th withir To th comp	ž	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
			- wardn		D057359	No	vember 1515 2004
				completed cause of death (Item 23a) (Typ		•	
			USHA NA		DIVISION ST, SA	isibury	MD 21804.
3%		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	,	
	Regist	rar	NOV 19	2004 Blogeres S.	Goods.		

OWEN, Eugene Wolford

1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day NOVEMBER 2  aminer  1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day NOVEMBER 2  4b. City, Town, or Location of Death 4c. City, Town, or Location of Death	2 Ti ( D 4b							
ledical OWEN WOLFORD NOVEMBER 2	3. Time of Death							
	Year 7.500 M							
Telegram in the second for the secon	21 2004 7:50P M							
	Journal of Death							
RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN	VASHINGTON							
1. Age (if yrs. last blittlady) Months Days Hours Min (Month Day Year)	9. Birthplace (State or Foreign Country)							
214-16-1245 - 84 Aug. 24 192	20 Maryland							
Usual Residence of Decedent  10a. State 10b. County 10c. City, Yown or Location	102 12 17 02 17							
	10d. Inside City Limits							
Maryland Washington Hagerstown   10e. Street and Number   10f. Zip Code   10g. Citiz	1 ∑ Yes 2 □ No							
10e. Street and Number 10f. Zip Code 10g. Citiz	en of What Country?							
	S.A.							
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	4. Race - American Indian,							
921 Frederick Street  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11. Never Married  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.							
To Proc Care 1   Voc 2 V No Cacción	Specify:							
	White							
15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kin (Specify only highest grade completed) (Give kind of work done during most of working	d of Business/Industry							
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Dispatcher  16. Kind (Do NOT use retired)								
Dispatcher F	Railroad							
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden S	Sumame)							
James Edward Wolford Lula Summers								
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or	Town, State, Zio Code)							
F. Evelyn Wolford - Wife 921 Frederick Street, Hagerstown,								
20a. Method of Disposition   20c. Loc cemetery, crematory or other place)   20c. Loc cemetery, crematory or other place   20c. Loc cemetery, crematory or other place)   20c. Loc cemetery, crematory or other place	ation - City or Town, State							
	ersburg, Maryland							
21. Signature of Funeral Service Licensee								
	m, Maryland 21740							
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate							
shock, or heart failure. List only one cause on each line.	Interval Between							
Immediate Cause (Final disease or condition	care MINS.							
resulting in death)  Lue to (or as a consequence of):								
Immediate Cause (Final disease or condition resulting in death)  a. Althus cluster Cardio-Vasculous described in the condition resulting in death)  a. Althus cluster Cardio-Vasculous described in the conditions.  Sequentially list conditions.  b. Cardio-Vasculous described in the conditions.	5400r							
Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	7503.							
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
that initiated events c								
d  IF FEMALE: 23c If yes outcome of pregnancy								
J I S S T I S S T I S S T I S								
	3d. Date of delivery							
1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)	Month Day Year							
1 Yes 2 No 9 Unknown 9 Unknown								
Page II Other significant conditions contribution to death but not condition in the	a contribute to the series of death?							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	e contribute to the cause of death?							
	No 3 Probably 4 Qunknown							
24a. Was an	24b. Were autopsy findings available							
1	prior to completion of cause of death?							
1□ Yes 2 1 No	1 Yes 2 No							
25. Was case referred to medical 26. Place of Death (Check only one)								
examiner?								
examiner?	Other (Specify)							
examiner? 1   Yes 2   No								
1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6								
1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6	occurred							
1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 47 Nursing Home 5 Residence 6								
1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Mork? M 1 Yes 2 No 28b. Time of Injury Work? M 1 Yes 2 No 28b. Discribe how injury 28b. Time of Injury Month, Day Year) 28b. Time of Injury At Home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? M 28b. Describe how injury 28b. Describe how injury 28b. Describe how injury 28b. Describe how injury 28b. Carting Accident 1 Yes 2 No 28c. Injury at Work? M 28b. Describe how injury 28b. Describe how injury 28b. Carting Accident 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work?	occurred  Number or Rural Route Number,							
1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6   27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	Number or Rural Route Number,							
1	Number or Rural Route Number,							
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 6  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No  28c. Injury at Work? M 1 Yes 2 No  28d. Describe how injury Work?	Occurred  Number or Rural Route Number,  nd manner as stated. lace, and due to the cause(s)							
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Other. Warring Home 5 Residence 6  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office  28e. Place of Injury - At home, farm, street, factory, office  28e. Place of Injury - At home, farm, street, factory, office  29e. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) a and manner stated.	Occurred  Number or Rural Route Number,  nd manner as stated. lace, and due to the cause(s)							
1	Occurred  Number or Rural Route Number,  nd manner as stated. lace, and due to the cause(s)							
1   Yes   2   No	Occurred  Number or Rural Route Number,  nd manner as stated. lace, and due to the cause(s)							
1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year) 28b. Time of Injury Mork? M 1 Yes 2 No  28c. Injury at Work? M 1 Yes 2 No  28d. Describe how injury 28d	Occurred  Number or Rural Route Number,  nd manner as stated. lace, and due to the cause(s)							
examiner?  1   Yes 2   No  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA  Other: 4   Nursing Home 5   Residence 6    28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work? M 1   Yes 2   No  28c. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date  28d. Describe how injury (Month, Day Year)  28d. Describe how injury (Month, Day Year)  28d. Describe how injury (Month, Day Year)  28d. Describe how injury (Street and City or Town, State)  28f. Location (Street and City or Town, State)  29d. Date  29b. Signature and title of certifier  29c. License number  29d. Date	Number or Rural Route Number,  nd manner as stated. lace, and due to the cause(s)							

			For State Registrar	State of M	laryland /	Departme		ealth and I		giene 20 (	04 38568	
	Physici /Medie Examir	al	1. Decedent's Name (First, Middle Lhrīstoph 4a. Facility Name (If not institution)	er Whoe				Location of Death	2. Date of De Month	Day Y  9 20 4c. County of	Year 3. Time of Death	
	Funeral Director		5. Social Security Number 215-94-4888 Usual Residence of Decedent	6. Sex 7. A	Age (In yrs. last b	oirthday) If Un Yrs. Monti	der 1 Year Ins Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da		D. Birthplace (State or Foreign Country) GERMANY	
	vith the Marylan tor 28a-1 show be notified at	Director	10e. Street and Number	ARUNDEL			Zip Code			10g. Citizen of Wh	10d. Inside City Limits 1 ☐ Yes 2 No at Country?	
121215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other then "netural", or Items 23a or 28a-1 show of other then "netural", or Items 13a or 28a-1 show event, I've Marylal Examilied at	i by Funerai	1218 HILLTOP D  11. Marital Status  1 Never Married 2 X Mar  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1  Yes 2	6? [ No	13. Was De If Yes, s	1401 cedent of His pecify Cubar 2 X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	USA  14. Race - Black, Specify:	American Indian, White, etc. WHITE	
	filed within 72 ho Hygiene. other then "netun ent, I're Madical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	nt's Education est grade completed)  College (1-4ol	r 5+)	a. Decedent's U (Give kind of life. DO NO	work doné d T use retired) OR	uring most of wor		16b. Kind of Busin  CONSTRU  Maiden Sumame)		
Maryland	2 should and Mer Is marke	To Be	LLOYD BENNETT  19a. Informant's Name/Relations	WHEELER ship (Type, Print)			ess (Street a	JANET V	VILKINSO	N er, City or Town, Sta		
Baltimore, I	parmit. Pages 1 and Department of Health Important: If Item 27 any injury or othar ti once.		20a. Method of Disposition  1 Burial 2 Commation  4 Donation 5 Other (3	3 □Removal from State	20b. Place cemet	of Disposition (If ery, crematory of CREMAT	Name of or other place  ORY	11/1	Date 1/2004	APOLIS, M 20c. Location - Ci  CATONSVI	ty or Town, State	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or Injury that initiated events resulting in death) Last	a	ed the death. Do	a of):	HAMROC	K ROAD,	CHESTER	, MD 216		
.O. Box 68760	death certificate e attending phys d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2  ☐ Fetal deat at time of death	th 3□Ectopic 5□Other	pregnancy (specify)			23d. Date of Month	,	
ecords, P.	The taw requires that the de tte has baen signed by the a bage 2 should be detached f	by								id tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown		
Vital Rec		e Compieted	25. Was case referred to medica	.1		1 <b>1 2</b> Yes 2				psy prior to completion of cause of death? 2 □ No 1 □ 7es 2 □ No		
Division of Vi	ding Phys n. After this funeral di	ation: To B	L	28a. Date of Ing (Month, D	28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28c. Injury at Work?  28d. Describe how injury						Specify)	
DIVIS	spitel or ours afte	al Certification:	3 Suicide 6 Could 4 Homicide determ  29a. Certifier 1 Certifyi	nined 286. Place of Ir building, a	njury - At home, f etc. (Specify)	ne death occur	ad at the time	e, date and place,	City or Tow	n, State)	or Rural Route Number, er as stated.	
	To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical 29b. Signature and title of certifie	and manner s	of examination a	nd/or investigati	on, in my opi 29c. License P17747	nion, death occur number	red at the time, o	date and place, and	due to the cause(s)	
10	RICK	te	30. Name and address of person  Fraclenich  31. Date filed (Month, Day, Year,	0. S. Regist	tear's Signature	(Type, Print)			, BALTI	MORE, MD	21201	
	Registr		NOV	1 2 2004	Enguer L	# Son	de					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N. 200 L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Agnes Alvina Ward Williams November 9, 2004 2:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Home, Inc. Prince Georges Hyattsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
April 29,1920

9. Birthplace (State or Foreign Country)
North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 M 200 F 84 Yrs 244-38-0973 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or Itams 23a or 28a-f show officer must be notified at 1 Yes 2 □ No Completed by Funeral Director Maryland Prince Georges **Hyattsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5805 Queens Chapel Road 20782 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should ba filed within 72 hours after of and Mantal Hygiene.
Is marked other than "neturel", or Itar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: than "neturel", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Holiday Inn Hotels 3rd grade Housekeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Haddox Lizzie Ward Ralph ဥ Pages 1 and 2 should nent of Health and Man 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I 629 Hampton Drive; Oxon Hill, Maryland 20745 Lige Edward Williams (Son) Oc. Location - City or Town, State Pollocksville, 20a. Method of Disposition 20b. Place of Disposition (Name of Free WIII Chapel F.W.B. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Nov. 20, 2004 Church Cemetery North Carolina <sup>22</sup> R. N. Horton Company Morticians, Inc. 21. Signature of Funeral Service Ligensee 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End State Alzheimer's Disease **Physician** /Medical Due to (or as a consequence of): **Examiner** DiabetesMellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760, Physician/Medlcal the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Sacral Decubitus 2X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy perform certificate 2X No 2□ No 1 🗌 Yes the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2**X** No 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation after death. 1 🗌 Yes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaref D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D 51520 22, 2004 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 Bahram Pishdad, M.D.; 9801 Georgia Avenue; Suite 3 41; Silver Spring, Maryland Registrar

**ORIGINAL** 

Division of Vital Records, P.O. Box 68760,

		For State Registrar	State of Maryland		epartment of H Certificate of I			ene 001	38571
		1. Decedent's Name (First, Middle, La					Date of Death     Month		3. Time of Death
Physici: /Medic		CORA E. WILL	IAMS				10	. 0	4 1935 M
Examin		4a. Fecility Name (If not institution, gir	re street and number)			Location of Death		4c. County of	
		TENINSULA REGIO	ONAL Medical	Lew?	4	136414		Wico	
Funeral			Sex 7. Age (In yrs. la 1 □ M XIXF		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent	84				July 26	,1920	Virginia
yland Iow		10a. State 10b. County		Town	or Location	т			10d. Inside City Limits
Mar Be-f st	ţo	DE Sus	sex			Laurel	_		1 Yes 2 □ No
th the or 28:	lrec	10e. Street and Number	II 6+1 C+		10f. Zip Code	9956		g. Citizen of Wh	
after death with the Maryland or items 23s or 28a-f show	Funeral Director	RD3 Box 370E							
ar deg	nne	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	). 	<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
rs afti	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1		1 ☐ Yes 24☐XNo	Specify:		Specify:	B1ack
2 hou	ted	15. Decedent's E	ducation	16a. C	Decedent's Usual Occup	ation	. 1	6b. Kind of Busi	ness/Industry
hin 7.	Completed	(Specify only highest gi	College (1-4or 5+)	()	Give kind of work done of the contract of the	during most of work d)	ing		
od wit	Com	6th		D	omestic W			Private	Homes
be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	t)				e (First, Middle, M		
ould Men Marke Marke	ပ္								
12 sh h and 7 le m raum		19a. Informant's Name/Relationship						-	
1 and Healt em 2		Moses Archer/N 20a. Method of Disposition	20b. Pla	ace of E	3 Box 370. Disposition (Name of		n St.Lai		E 19956 ty or Town, State
ages int of t: If it		12 Burial 2 ☐ Cremation 3 [	_IRemoval from State	-	crematory or other place	· .			Delaware
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the modified at once.		' 4 ☐ Donation 5 ☐ Other (Spec 21. Sign@ure of Funeral Service Lice	A STATE OF THE PARTY OF THE PAR	Mat	thews Cen		and the second second		Home, PA
permi Depar Impor any ir		Mustine	M. Coale			ain St.			
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death.	. Do no		-			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Ascu	6					Onset and Death
/Medical		resulting in death)	Due to (or as a consequ	ence of					
Examiner	_	Sequentially list conditions,	0.	144		scular	Ds		
ed sit	aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of	):				
xecuted and II-transit	×	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of	):				
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	alE		d						
rifficate ng phy as the	edlo		u.						
eath cert attending for use	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		3 □Ectopic pregnancy	,		23d. Date	
deat ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at time of de 9□Unknown		5 Other (specify)	<u> </u>		Month	Day Year
at the de	Physician/Medical	9 Unknown		ta:		. fo Book I	OO - Did Ash		and the second of death?
uires thai signed b	þ	Pair ii, Other significant containing to death out for resulting in the orderlying cause given in Pair i.							☐ Probably 4 ☐ Unknown
w requi	Completed	0-610	1en 19				-		
The law	d H			<del></del>			24a. Was an autopsy perform	l prio	re autopsy findings available or to completion of cause of ath?
							1 ☐ Yes 2	No 1□	Yes 2□No
Physician: r this certifica	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	R/Out	patient 3 DOA Oth		h <i>(Check only one</i> ome 5 □ Resider		(Specify)
9 Phy ar this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Tir	me of 28c. Injur		28d. Describe hov		(Ороспу)
nding ath. r: Afte e fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	.inj		Yes 2 □No			
r Atte er de; recto by th	ertification;	3 Suicide 6 Could not determine			m, street, lactory, office		28f. Location (Stre City or Town,		or Rural Route Number,
ital or rrs aft ral Dir led in	O								
	=	29a. Certifier 1 Certifying F	hysician: To the best of my know	vledge,	death occurred at the tir	me, date and place,	and due to the car	use(s) and mann	er as stated.
Hosp 14 hou Fune Fune	ice	(Check only 2 Medical Exa	miner: On the basis of examinati	ion and	or investigation, in my o	pinion, death occur	red at the time, da	te and place, and	d due to the cause(s)
To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Example)  29b. Signature and title of certifier	nminer: On the basis of examinati and manner stated.	ion and	or investigation, in my o				d due to the cause(s)  Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 M.D

29b. Signature and title of certifier

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dabylal Day, MD. 106 Milford ST # 504B Saliebury

29d. Date signed (Month, Day, Year) 10/28/04

MD21804

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 4 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Year LEE WASHINGTON ANTHONY 2004 NOVEMBER 17 6:30 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death KENSINGTON NURSING HOME KENSINGTON MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 1⊠M 2□ F Months Days 578-90-1795 43 April 2 1961 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 □ No Capital Heights Prince George's 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1303 Chapel Lane 20743 U.S.A. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 Yes 2 TNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Shipping Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Juanita Foster

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1303 Chapel Lane Capital Heights, Maryland 20743

7474 Landover Road Landover, Maryland 20785

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

MINUTES

11/22/04 Landover, Maryland

J. B. Jenkins Funeral Home

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

2

Leroy Washington

4 ☐ Donation 5 ☐ Other (Specify)

21. Signatur → I Funeral Service Licens∝

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

Bonita C. Washington/Wife

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

Funeral

Director

r than "naturel", or items 23a or 28a-f show the Medical Examinat must be notified at

27 is marked of treumatic even

Department of Health a important: If item 27 is any injury or other tree once.

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

3altimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): Physiclan/Medical Examiner attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEVERE DIABETES MELLITUS δ Completed DIABETIC GASTROPORESIS 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yeer) Certification: 28b. Time of 28c. Injury at Work? 1- Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a, Certifier Medicai 29b. Signature and title of stifier

The law requires that the death certificate be executed 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ thknown 1 ☐ Yas 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Director: After this certificate has It in by the funeral director, page 2 s 2 AK 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred death. To the Hospital or Atter within 24 hours after de: To the Funeral Director completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Se 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20b. Place of Disposition (Name of cometery, crematory or other place)

Harmony Cemetery

22. Name and Address of Facility

State Registrar NOV 2 3 2004

GARRY N. ROSENBAUM JTZO FARRAGUT AVE. KENSINGTON, MY ZOS95 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 11 2004 **Physician** Edith A. Wolridge November 12:15 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Larkin Chase Nursing & Rehab. Bowie Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 4, 1925 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ XF Director 146-20-8567 79 Yrs. Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show The Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 12108 Augusta Drive 20769 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 2 should be filed within 72 hours after or and Mental Hygiene.
Is marked other than "natural, or Iter Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black δ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Waitress Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Cleveland Braxton Sarah Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is Dianna P. Wolridge/Daughter 12108 Augusta Dr., Glenn Dale, MD 20b. Place of Disposition (Name of cemetery, crematory or other pages). 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iter
any injury or oth Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Maryland National Mem. 11/18/2004 Laurel, MD 21. Sign ture of Funeral Service Lic nsee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in eath) **Physician** Cardiomyopathy Years /Medical Due to (or as a consequence of): Examiner Hypertensive Cardio Vascular Disease Years Sequentially list conditions, if any leading transcribes cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit Atherosclerotic Cerebro Vascular Disease Years and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed s certificate has b lirector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 **X**No 1 Yes 2 🗌 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 📉 No Other: 4XI Nursing Home 5 Residence 6 Other (Specify) 40 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 XNatural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours af 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ake D20108 November 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane, Bowie, MD 20715 Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 2 2004 Registrar

				partment of Health and ertificate of Death		iene g. N2004 38574
	Physic /Medi		TUTC PTATO MINICKO		2. Date of Death	
	Exami		4a. Facility Name (If not institution, give street and number)  Manor Care - Largo	4b. City, Town, or Location of Dea		4c. County of Death Prince Georges'
	Funeral Director		5. Social Security Number  579–52–8900  G. Sex  7. Age (In yrs. last birthday 65 Yrs. Usual Residence of Decedent	Months Days Hours Mir		Year) 9. Birthplace (State or Foreign Country) 938 Maryland
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examinative notified at	ctor	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	with the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	ns 234	Funerai	3052 Stafford Street  11. Marital Status  12. Was Decedent Ever in U.S. 13.	21223		U.S.A.
920	ous after death with the Manylar rat', or Items 23a or 28a-f show Examinar must be notified at	ğ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland 21215-0036	f within 72 hours iene. r than "natural", I'm Medical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation a kind of work done during most of wo DO NOT use retired)	orking 16	6b. Kind of Business/Industry
d 2	be filed v tal Hygie d other t event, III		12th Me	echanic		Private
rylan	d tail	To Be	James Winters	Ruby	me (First, Middle, Ma Hawkins	
	and 2 sealth an n 27 is in traus			ing Address (Street and Number or R Glenoak Road; La		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic. <u>0008</u> .		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, crei	osition (Name of matory or other place)	Date 20	Oc. Location - City or Town, State
Baltii	permit. F Departme Importar any injur		Kiveldal			iverdale, Maryland eral Services
	ifficate be executed  g physician and as the burial-transit as the burial-transit	i Examiner	23a. Part 1 Enter the disease, or complications that caused the death. Do not ent shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		Land, Mar	t, Approximate Interval Between
.O. Box 68760		Physiclan/Medical		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires tha been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		co use contribute to the cause of death?
		e Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
lo u	ng Phys fter this ineral dii	on: To B	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation  28a. Date of Injury 28b. Time of Injury	Out and	th (Check only one) ome 5 Residence 28d. Describe how in	e 6
DIVISION	I o the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Certificati	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location (Stree City or Town, St	t and Number or Rural Route Number, tate)
	To the Hospital or All within 24 hours after on the Funeral Directompletely filled in by	edicai (	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death 2 Medical Exeminer: On the basis of examination and/or investigation and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	Common Total		29b. Signature and title of certifier  M	29c. License number	2	Date signed (Month, Day, Year)  ovember 19, 2004
M	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, P Donald George, MD 3001 Hospital Dr	Print) Cive; Cheverly, Ma		
	Stat Registra	_	31. Date filed (Month, Day, Year) 2. Registrar's Signature NOV 2 2 2004	W	атутало 2	0785

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			1 - For State Registrer	State of M	laryla		artmer <i>rtifica</i> i			ınd M	ental Hy	giene Reg. No.	71111	l,	3857	15
ı	Physic		1. Decedent's Name (First, Middle  Nanu	e, Last)	٨						2. Date of De Month	Day	Yea	<u>.</u>	3. Time of Death	n M
}	/Medi Exami		4a. Facility Name (If not institution	n, give street and number	)		4b. City	Town, or	Location of	f Death	V ·	4c.	County of De	eath	17 '	
			University	of Manyla		SIC			non							
L	Funeral Director		5. Social Security Number 217-32-6215 Usual Residence of Decedent	6. Sex 1 □ M 2 🖾 F	ge (In yrs 69	. last birthday) Yrs.	If Unde Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da Nov 1	th 19, <i>Year)</i> 1935	9. E Mo	Birthplac Country nte	e (State or Fore y) Vue, MD	ign
	yland now		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d	. Inside City Lim	its
	e Mar	ctor	MD Frede	erick	Br	unswich	K								1 <b>X</b> Yes 2 □	No
	vith th	Director	10e. Street and Number			-	10f. Zij	Code	1.6			10g. Citi	zen of What	Country	?	
	eath v	Funerai	63 Wenner Drive	12. Was Decedent	Ever in 1	19 12 1	Was Dasa	217		i=2 /C= a	aif. V		USA		In all a	
Maryland 21215-0036	72 hours after death with the Maryland "natural", or Items 23e or 28a-1 ehow idical Examinar must be notified at	by	t ☐ Never Married 2⊠ Marr 3 ☐ Widowed 4 ☐ Divorced	Amed Forces'	?		Was Dece If Yes, spe 1☐ Yes		Specify:	In? (Spe Puerto I	cify Yes or No Rican, etc.)	)-	14. Race - Ar Black, Wi Specify: V	nite, etc	à.	
5-0		eted	15. Deceden (Specify only higher			16a. Dece	dent's Usu	al Occupa	tion uring most	of working	na	16b. Ki	nd of Busines	ss/Indus	stry	
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9	ygi f.		12 17. Father's Name (First, Middle,	Last)			CI	eane		's Name	(First, Middle		derick	c, M	D	
an	be d o d	To Be	William Arthur								ry Genz		<i>Sumame</i>			
ary	2 should be and Ment le marked raumatic e	-	19a. Informant's Name/Relations.			19b. Mailir	ng Address	(Street a			Route Numb		r Town, State	, Zip Co	ode)	_
	and 2 ealth a m 27 le		William J. Ward	l, Sr., Husb		_			ve, Bi	runs	wick, N	1D 2	21716			
Baltimore,	~ I i i i		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)		Bro	Place of Dispo cemetery, cren DWNSVII	natory or o Le He	me of other place eight	s 1	1/20	ate 0/04		cation - City on nsvill			
Balt	permit. Pages Department of Importent: If I any injury or		21. Signate of Fin, al Service	Villiams, Ow	mer		John	T. W:		ns F	uneral ad, Bru			21	716	
d	Pnysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each if a Due to (or as	ysis	th. Do not ente	er the mod	de of dying	, such as c	ardiac or	respiratory a	rrest,		In	pproximate terval Between nset and Death days	
r	Examiner				CONSEC	querice ory.										
-	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consec	quence of):										
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Exa	that initiated events resulting in death) Last	Due to (or as	a consec	quence of):										
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3	Ectopic pr Other (sp					2	3d. Date of d	elivery Da	y Year	
ds, P	Se Ge	by	Part II. Other significant condition	ns contributing to death b	-	sulting in the ur	nderlying c	ause give	n in Part I.			bacco us			ause of death?	vn
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Vital Record		e Completed	25. Was case referred to medical								autop perfor 1 Tes	med? 2 No	prior to death? 1 \( \text{Ye}	compl	findings availabetion of cause o	
<u> </u>	Physiclen: r this certific ral director,	To B	examiner?	Hospital:	ent 2	ER/Outpatient	t 3 DC	Other			(Check only o		Other (So	acih/l	100000000000000000000000000000000000000	-
ion of	or Attending Phye after death. Director: After this in by the funeral dii	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Da	ıry	28b. Time of Injury		8c. Injury Work	at es 2 □ No	28	Bd. Describe h	ow injury	occurred	scily)		
Division	itel or Atters after de el Directo	Certification:	3 Suicide 6 Could r 4 Homicide determi		jury - At h c. <i>(Specit</i>	ome, farm, stre	et, factory	, office		21	Bf. Location (S City or Tow	Street and m, State)	Number or F	Bural Ro	oute Number,	
	To the Moepitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier  (Check only one)  Certifyin  2 Medicel I	g Physicien: To the best Exeminer: On the basis o and manner st	it examina	wiedge, death tion and/or inv	occurred estigation,	at the time in my opi	e, date and nion, death	place, ar occurred	nd due to the d d at the time, d	ause(s) a	and manner a place, and du	s stated	d. cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		2		290	. License			- 3	29d. Date	signed (Mon	th, Day	, Year)	
_	,		1	my ot	<u></u>	MD.		AUL	1176	43	57	11	16/4			
5	>	1772	30. Name and address of person to	italy 1	Pec	k 1	Print)						•			
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV	32. Registr	ars Signa	iture	6	Son	u Kal	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ľ	1 - State Registrar	Otate of Island	i ytaria i		tificate of L		R	eg. No:	nni	20576
ī	Physicia	an	1. Decedent's Name (First, Middle, Las	Leonard Y	OHNEE.	р те	•		2. Date of Deat Month	Day	Year	3 Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		OUNKE.	K, Jr	4b. City, Town, or		DVEMBE		ounty of Deat	
	Examin	er	Saint Joseph		Cent	er		Towso	n		Bal	timore
	Funeral Director		5. Social Security Number 6. S 217-56-2447	ex 7. Age	(In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Dec. 14	Year)	9. Birt Co Ma	hplace (State or Foreign buntry) ryland
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	Maryl	tor	Maryland Washing	ton	Hag	erst	own					1 <b>X</b> Yes 2 ☐ No
	or 288	Funeral Directo	10e. Street and Number				10f. Zip Code		1	_	n of What Co	-
	s 23a	erall	320 South Mont Va	Illa Avenue	ver in II S	13 1	_	21740	city Yes or No-		U.S.A.	
2-0036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or itams 23a or 28a-f show event, the Modical Exching routh to notified at	by	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:			fYes, specify Cubai I□Yes 21⊠No	spanic Origin? (Spe n, Mexican, Puerto f Specify:	Rican, etc.)		Black, Whit	
ה ה	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	1	6a. Deced	lent's Usual Occupa kind of work done of	ation furing most of workin )	ng	16b. Kind	of Business/	/Industry
7	within ane. than	Completed	Elementary/Secondary (0-12) 0-12	College (1-4or 5+				) L inspecto		Launc	h head	ls mfg.
7 0	illed Hygi other	e Cc	17. Father's Name (First, Middle, Last,					18. Mother's Name				
yland	uld be Menta irkad itic ev	To B	Russell	Leonard You	unker	, Sr.		Pa	tricia	Ann	Munson	1
Mar	2 sho and l is me		19a. Informant's Name/Relationship (					and Number or Rura				
e,	ges 1 and 2 should be file of Health and Mental Hy, If itam 27 is marked othe or other traumetic event,		Marcia Younker -	Wite	120b. Plac	A OI DISDO	smon <i>rivame</i> or		renue, F	lager:	stown,	Maryland 21740 Town, State
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif	(y)		Hil	natory or other place	· MOVEII	2004			n, Maryland
g	Depar Impo any ir		21. Signature of Funeral Service Licer	Packen								21740 Maryland
H			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	the death. (	Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	a _ANOXIC	ENC	EPHA	LOPATHY					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a								
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	cuted nd ransit	Examiner	that initiated events				ARCTION					
Ď,	icate be executed physician and the burial-transit	EX EX	resulting in death) Last	Due to (or as a	consequen	nce of):						
68/PU	tificate ng physi as the l	Medical		d								
O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 10 ☐ Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			230	d. Date of de Month	livery Day Year
ב	res that the signed by be detact		Part II. Other significant conditions	contributing to death bu	t not resultin	ng in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires been sign should be	ed by							1 🗆 Y	es 2001	No 3□Pi	robably 4 Unknown
Records,	e la has ge 2	Completed							24a. Was a autops perform	sy	24b. Were au prior to death?	utopsy findings available completion of cause of
Vital	ilcian: Th certificate rector, pag	Be C	25. Was case reterred to medical examiner?					26. Place of Death		-		
o 	Physic this ce at dire	P	1 ☐ Yes 2 No	Hospital: 1X Inpatien			othe	4   14d15111g 1101	ne 5 🗆 Reside			cify)
	ding F h. After tuner	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	Bb. Time o Injury	Work	k? Yes 2 □No	EGG. Describe III	ow injury c	Accurred	
Division	or Attanding Physician: after death. Diractor: After this certific I in by the funeral director,	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	De Blace of Injur		e, larm, sti	reet, lactory, office		281. Location (S City or Town	treet and f n, State)	Number or Ri	ural Route Number,
_	Hospita 4 hours Funaral ely filled	Medical C		hysician: To the best of miner: On the basis of and manner stat	examination							
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of codifier	P A.	7		29c. License	e number	2	29d. Date s	signed (Most	th, Day, Year)
			) (cnoth	Tow III.	V.		D 2	4034		11	1191	04
. 1	4-441		30. Name and address of person who	completed cause of de	ath (Item 2)	За) (Туре.	Print)					
9			31. Date liled (Month_Day_Year)	D 76.71 32. Redistra	OSL E	R DR	IVE TOW	SON MARY	LAND E	1204	+	
	Sta Regist	ate . rar	31. Date liled (Month, Day Year) NOV 2 3	2004 Dene	_		peles					

			For Stata Registrar		laryland / Dep Ce		lealth and M	Mental Hy	•		3857 <b>7</b>
	Physic	an	Decedent's Name (First, Middle     Name (First, Middle			-		2. Date of Dea	ath Day	Year 3	. Time of Death
	/Medi		Joseph	AKer				12	3 2	1004	1648 M
	Examir	ner	4a. Facility Name (If not institution	0	r)		r Location of Death	1	4c. County		
			Johns Hopkins	Bayview	A contract to the decision of	Ballm	-	T		, 12more	
9	Funeral Director		5. Social Security Number  220-14-7827  Usual Residence of Decedent	6. Sex 7. A 1 ★ 2 □ F	Age (In yrs. last birthday,	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01/26/	1923	9. Birthplace Country)	(State or Foreign
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show te Madical Examirer must be notified at		10a. State 10b. County		10c. City, Town or L	ocation				10d.	Inside City Limits
	Man Ff sh	ţō	MD Balti	more	Baltim	ore					1 ☐ Yes 2 No
	r 282	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?	,
	23e c	a	8812 Avenue	В		21219		Ţ	J.S.A.		
	ems ems	ner	11. Marital Status	12. Was Deceder Armed Forces	.7	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	14. Race	- American I k, White, etc.	ndian,
98	or It	Y Fu	1 Never Married 2 Marr	ed 1 XYes 2 If Yes, Give	™ 1943_	1 ☐ Yes 2 No	Specify:	7110411, 010.7	Specify:		
8	hours urel',	d b	3 Widowed 4 Divorced	Year or Dates	1940					AATIT	
21215-0036	"net	Completed by Funeral Director	15. Decedent (Specify only highes	s Education t grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Bu	siness/Indust	ry
12	withii ene. then	dmc	Elementary/Secondary (0-12) 1 2	College (1-4o	r 5+)	rpenter	*/		Doth1 o	ham C	1+001
	filed Hygi other		17. Father's Name (First, Middle,	.ast)	Ca	rbencer	18. Mother's Nam	ne (First, Middle,	Bethle Maiden Sumame		reer
an	ld be ental ked c	To Be	Joseph L. A	kers			Svhi1	Branno	n	,	
Maryland	shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relationsl		19b. Maili	ng Address (Street				State, Zip Cod	de)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other treumetic event, tre Maxical Examinet must be notified at once.		Alice Akers/	Wife		2 Avenue					
Baltimore,	s 1 a of Hez item othe		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place		Date	20c. Location - 0		State
Ë	Page ient c int: if iry or		1 ☐ Burial 2 <b>X</b> Cremation 1 ☐ Donation 5 ☐ Other (Si		Bayview		l l	06/04	Baltim	ore.	MD
alti	mit. partm sorte / inju		21. Signature of Funeral Service I	icensee		2. Name and Addres					
m	permi Depar Impor eny ir		1 Ent	San-		69 Rivie					
8760,	Physician /Medical Examiner physician and physician and the pruial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	s a consequence of):	rem fell	vre				set and Death
P.O. Box 68	the death certific by the attending pached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of delivery th Day	y Year
	w requires that been signed t should be det	by	Part II. Other significant condition	ns contributing to death	but not resulting in the u	, ,	en in Part I.		bacco use contri es 2 <b>⊠</b> No :		ause of death?
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of V	Physicien: this certificaral director, i	2	1 Yes 2 No	Hospital:	tient 2 ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing Ho	ome 5 Reside	ence 6 Other	r (Specify)	
Division o	ending Physicien: The lasth. or: After this certificate ha he funeral director, page		27. Manner of Death  1 Natural 5 Pending 2 Accident investig	ation	jury 28b. Time o lnjury	Work	/ at <br Yes 2 □ No	28d. Describe ho	ow injury occurre	d	
Divi	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attencompletely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of II	njury - At home, farm, str atc. (Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Number n, State)	r or Rural Ro	ute Number,
	the Hospi in 24 hou the Funer pletely fill	Medical	one)	Physician: To the bes xaminer: On the basis and manners	t of my knowledge, deat of examination and/or in stated.	vestigation, in my or	pinion, death occur	and due to the c red at the time, d	ause(s) and man ate and place, ar	ner as stated nd due to the	l. cause(s)
	To To	2	29b. Signature and title of certifier	7_		29c. License			9d. Date signed		Year)
•	( )		1 / 0				s - 000		12/3/	04	
į	1/		30. Name and address of person	who completed cause of	death (Item 23a) (Type,	Print)	0 1				
	V		31. Date filed (Month, Day, Year)	M.D. )	ohns Hapkins	Deyview	Salton	ore MD	)		
	Sta Registi		DEC 0 7 2	004 Hegis	death (Item 23a) (Type.	the state					

	-	For State Registrar	State of Ma	aryland .	•	artment <i>tificate</i>			and M		iene O O	4	38578
D1	4	1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month	th Day	Year	3. Time of Death
Physicia /Medica	1	Verna Joan								12		2004	0100 M
Examine	er	4a. Facility Name (If not institution, give st	•			4b. City, T	own, or time		of Death			y of Déath Baltin	na tra
*		6 Juliet Lane, Uni 5. Sociał Security Number 6. Sex		e (In yrs. last	birthday)	If Under 1	Year	If Under:		8. Date of Birtl	)		
Funeral Director			M 21XF	58	Yrs.	Months	Days	Hours	Min.	May 11	1946	Mar	olace (State or Foreign otry) Yland
pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation						1	0d. Inside City Limits
faryla shov	5		0	100. 010, 1	OWIT OF E0	Balti	man	2					1 ☐ Yes 2 ☑ No
n the Marylander 28a-f show	rect	Maryland Baltimor  10e. Street and Number	.e			10f. Zip (		۷			I 0g. Citizen of	What Cour	ntry?
ath with 123s or	<u> </u>	6 Juliet Lane, Un	it 303					2123	6		u.	.S.A.	
UU36 hours after death with the Maryland urat; or items 23s or 28s-f show at Examinar must be multilized at	Funeral Directo	11. Marital Status	2. Was Decedent E Armed Forces?		13.	Vas Decede f Yes, specif	ent of His fy Cubar	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - Americ	ean Indian, etc.
5-UU36 72 hours after dea natural; or items dical Examiner m	by Fu	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	10	1	I ☐ Yes 2		Specify:			Speci		
Z15-UU36 thin 72 hours af e. en *natural; or Molical Ex-mi	ed b	15. Decedent's Educ	ation	1	6a. Deced	lent's Usual	Occupa	ition			16b. Kind of E		
within 72 ene.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work DO NOT use				ng		,	
Z will will will will will will will wil	Com	12th Grade			Elec	tronic	us We				Westi	_~	se
Da libe fill dott	Be	17. Father's Name (First, Middle, Last)  Charles McCull	ah				ĺ	18. Mothe		(First, Middle,	Maiden Suma & &MOJN.	me)	
	ို	19a. Informant's Name/Relationship (Typ			19b Mailir	n Address	(Street a			M Route Numbe		. State. Zic	(Code)
Mar nd 2 sh lth and 27 is m	1		husband)							3, Balt			
s 1 and 1 Healt itam 2 othar		20a. Method of Disposition				sition (Name				Date	20c. Location		
Pages nent of I		1 🔀 Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)			Josep	oh Ch.	Cer	n. 1					MaryLand
Baltimore, permit. Pages 1 au pepartment of Hea Importent: If item any injury or otha		21. Signature of Funeral Service License	е		111					imunek			2.5
n go = 29		W CONTINUE	etions that savend	the death [						alimor		21236	Approximate
Physician		23a. Part1. z ter the dise se, or complic shock r hear failure. List only on Immediate Cause (Fig. 1) disease or condition	e cause on each lin	TE	му	o CA	RD.	IAC	( A	FARC	TION		Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	a consequen	ice of):		7	V.O.	T	PARC			
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uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequen	ice of):								
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x 68 sertifica ding ph	Mec	IF FEMALE: 23	sc. If yes, outcome	of pregnancy	,					40.44	23d D	ate of delive	arv.
. BOX 68 / 60, death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3	Ectopic pre Other (spe						onth	Day Year
	hysi	9 Unknown	9□ Unknown										
S tes the igner ig	ρ	Part II. Other significant conditions conditions HYPELLIPIDE		ut not resultir	ng in the u	nderlying ca	use give	n in Part I.			bacco use cor es 2□No	ntribute to th	ne cause of death?
aw requir s been si 2 should	Completed									24a. Was a	an 24b.	Were auto	psy findings available mpletion of cause of
The lav	E O									perfor		death?	2□ No
	BeC	25. Was case referred to medical examiner?								(Check only or			
hys this	2	1 Yes 2 No		nt 2 ER						me 5 Resid			y)
Junera	on	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day	Year) 28	lb. Time of Injury	M 28	Bc. Injury Work	at :? /es 2.⊟I		28d. Describe h	ow injury occu	rrea	
DIVISION I or Attending after death. Diractor: After d in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home	e, farm, str							ber or Rura	I Route Number,
DIV all or A	Certification:	4  Homicide	building, etc	c. (Specify)						City or Tow	n, State)		
	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin		examination									
within To the compl	Me	29b. Signature and title of certifier						number			9d. Date sign	ed (Month,	Day, Year)
. N		June Nol	nd no			1	29	70-10	2	1	ec. 3,	2004	
/19		30. Name and address of person who could Dr. Serena Nolan,					arkv	ille,	, MD	21234			
Star Registra		31. Date filed (Month, Day, Year)  DEC 07	32. Registra	ar's Signature	9	4	Son	Al s	*1				

DHMH 17 Rev 1/2001

		1 - For State Registrer	State of Maryland	d / Depa <i>Cer</i>	artment of H tificate of L	ealth and Death		giene Reg. No.		38579
Physici		1. Decedent's Name (First, Middle, Last) Mary Jane Ame	rsbach				2. Date of De Month DECEMB	Day	Year	3. Time of Death
/Medio Examir		4a. Facility Name (If not institution, give s SAINT AGNES HEA	•		4b. City, Town, or BAUTIM			-	County of Death	*
Funeral Director		5. Social Security Number 217-14-0184 6. Sex	7. Age (In yrs. la M 2XF 81	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min	s. 8. Date of Bir Month, Da December	th 08°ar	922 Ne	nplace (State or Foreign untry) W York
aryland show		Usual Residence of Decedent  10a. State 10b. County		, Town or Lo						10d. Inside City Limits
ith the Ma or 28e-f	Director	MD. Baltimor  10e. Street and Number  2665 West Park dr		odlawn	10f. Zip Code	207		_	izen of What Co	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show amy rollury or other treumatic svent, I'm Medical Examinar must be notified at once.	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 1 No	6. 13. V	Vas Decedent of Hi f Yes, specify Cubar	207 spanic Origin? ( n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	-	ted Sta 14. Race - Ame Black, White	rican Indian, o, etc.
thours aft	ted by F	3₺ Widowed 4 □ Divorced  15. Decedent's Educ	If Yes, Give Year or Dates:	16a. Deced	l □ Yes 2Ñ No dent's Usual Occupa	Specify:			Specify: Wh	
d within 72 giene. ar then "na	Completed	(Specify only highest grade	College (1-4or 5+)	(Give life. L Cler	kind of work done d DO NOT use retired, k	uring most of w	orking		.F. & G	•
uld be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last)  DeWitt VanWinkle	2				ame (First, Middle, Louise St		,	
and 2 sho laith and N 127 is ma er treuma		19a. Informant's Name/Relationship (Type Mrs. Karen Armiger	e, Print)	19b. Mailin 2307	ng Address <i>(Street a</i> Overbrook	nd Number or F Drive,	Rural Route Number New Wind	er, City o dsor	Town, State, Z , Md. 2	ip Code) 1776
Pages 1 annot of He		20a. Method of Disposition 1	CO CO	metery, cren	sition <i>(Name of</i> natory or other place Park Ceme	tery 12	Date /09/04		cation - City or I	Town, State Maryland
permit. Departrimporte any inji		21. Signature of Funeral Service License	elner 1100 73	R.						Directors 21133-4784
Physician		shes, or heart failure. List only on Immediate Cause (Final disease or condition	eations that caused the death. e cause on each line. PSEUDOMEN				ac or respiratory ar	rrest,		Approximate Interval Between Onset and Death I MONTH
/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a consequent							
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ai Examiner	if any, leading to immediate cause Finer Incarrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or a))).	,		•				
Sertificate ding physise as the	/Medicai	IF FEMALE:	c. If yes, outcome of pregnan							
the death certification by the attending proched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 Mo 9 □ Unknown	1 Live birth 2 Fetal of 4 Pregnant at time of deaged Unknown	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of deli- Month	very Day Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions conductions CON GESTIVE HEI	_	-	nderlying cause give	n in Part I.				the cause of death?
The law ree e has bee age 2 sho	Completed	CHRONIC RENAL	FAILURE					rmed?	death?	opsy findings available ompletion of cause of
ysician: The is certificate hidirector, page	o Be C	25. Was case referred to medical	ospital: 1 ⊠Inpatient 2 □ E	R/Outpatien	t 3 DOA Othe	-	1 ☐ Yes eath (Check only of the side of t			2€No
anding Physiath. or: After this	ation: T	27. Manner of Death  1 ※Natural 5 Pending investigation		28b. Time of Injury	28c. Injury Work	at	28d. Describe h			-97
To the Hospitel or Attending Is within 24 hours after death or To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Tow	m, State) 	)	al Route Number,
To the Hospitel within 24 hours a To the Funerel I completely filled	ledicai	(Check only 2 Medicel Examin	icien: To the best of my know er: On the basis of examinati and manner stated.	rledge, death on and/or inv	estigation, in my op	inion, death occ	curred at the time, o	date and	place, and due	to the cause(s)
with To COUT	M	29b. Signature and title of certifier	ONNA BILU,	MD	29c. License	onumber 6607			e signed (Month)	5 2004
10		30. Name and address of person who cor	ENUE BA	LTIM	ORE, MI	21	229			
Sta 'Registr		31. Date filed (Month, Day, Year)  DFC 0.7 2004	22. Registrar's Signatu	y p	pails					

MARY JANE AMERSBACH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie ( ) 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Bupttner **Physician** 01:35 PM NORBERT George Pecember 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Baltimore Bultimore Bayview If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 9-1-1922 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 82 214-18-1393 Director Maryland Usual Residence of Decedent 10c. City, Town or Location
Baltimore 10a State 10b. County 10d. Inside City Limits 7 is marked other then "neturel", or Items 23s or 28e-f ehow treumatic event, the Madical Examinar must be notified at MD n/a Director 1 XYes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3808 Bank Street 21224 USA Funerai 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 □ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retired-Navy US Navy permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Importent: If them 27 is marked other the any injury or other treumation. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert John Buettner Marie C. Robinson 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Buettner Bank St. Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/13/04 Owings Mills, MD '4 ☐ Donation 5 ☐ Other (Specify) Garrisson Forest 22. Name and Address of Facility Joseph N. Zannino Jr.FH 21. Signature of Funeral Service Licensee area Baltimore, MD 21224/263 S. Conkling St. ennino 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Aspiration a weeks /Medical Due to (or as a consequence of). **Examiner** Alzheimers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Heart 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 2 Accident after death 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 Ka December Tower 110 600 N. WOIL & st., Doctors Lounge 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Compta

Kajesh

Johns

Hopkins

32. Registrar's Signature

Hospital

MD

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Robert Sherman Bundy, Sr. 5 2004 ecemper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Campus Bel Air Harkord If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1\\ M 2□F 62 Director 216-40-0454 1942 4. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f show other treumetic event, the Medical Examiner must be notified at Maryland 1 ☐ Yes 2 ☑ No Directo Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3001 Scotch Court 21009 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married me# 118596 12/05 124 ■ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specity: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Itam 27 is marked other than "na eny injury or other treumetic event, It a Marie once. Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Automobiles Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert W. Bundy Dorothu Mau Wagers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan M. Bundy (wife) 3001 Scotch Court, Abingdon, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 12/8/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Butimore, MD 21236 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Anemia Few days /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dile to (or as a nonsequence of) burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1□ Yes 2□ No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred or Attanding 14 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 2004 Registrar DHMH 17 Rev 1/2001

			1- State of Ma		artment of F rtificate of	leaith and Me <i>Death</i>	ntal Hygie Reg.		38582
	Physici	an	1. Decedent's Name (First, Middle, Last)			2	. Date of Death	Day Year	3. Time of Death
	/Media	cal	Helen Marie Brown				December	03 2004	6:35 AM
	Examir	er	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		Baltimo	r Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	g. Birthp	place (State or Foreign
	Director		226-26-8960 ¹□M 2⊠F	80 Yrs.	Months Days	Hours Min.	Month, Day, Ye pril27,1	ar) Cour	ntry)
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			1	0d. Inside City Limits
	Maryl f aho	tor	Maryland Baltimore	Essex				,	1 ☐ Yes 2XXXIo
	r 28e	irec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cour	ntry?
	23a c	aiD	1134 East Riverside Avenue		2122	21	t	J.S.A.	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ahow any injury or other traumatic evant, It a Modical Extensional and the rediffication.	Funeral Director	11. Marital Status  12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036	urs aff	by F	1 Never Married 2 Married 1 Yes 25 N 3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2∕CINO	Specify:		Specify:	ite
2-0	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	eation	166	. Kind of Business/In	
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d 2	filed v Hygie Ither t		10 17. Father's Name (First, Middle, Last)	Homem	aker	18. Mother's Name (I		Wn Home	
an	ld be ental ked o ic eva	To Be	Herbert K. Deaton			Gladys C		•	
ary	shou and M s mar	<b>)</b>	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street	and Number or Rural F			Code)
	and and ealth m 27 i		Tina Moore, Daughter			verside Ave		timore, Mo	1. 21221
Baltimore,	ges 1 if of H if ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo			200.	. Location - City or To	
ΞĒ	artmer artmer ortant injury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fundal Saprice Lineagers	Parkwood	_			rkville, M	
Ba	Depa Impo any ir	6	13		Br 407 Old F	<sup>ss of Facility</sup> ruzdzinski astern ave	Funeral	Home, P.A.	nd 21221
	250		23a. Part1. E The disease, or complications that caused to shoot heart failure. List only one cause on each line					ev, maryro	Approximate Interval Between
	Physician		Immediate Cause (Final diseas or condition	sons Di					Onset and Death
	/Medical Examiner			consequence of):					7.00
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):					
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0,	e exerian ar	Exa		consequence of):					
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai	d						
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	the atte	Physician/M	in the past 12 months?  1 ☐ Yes 2 TGVio 4 ☐ Pregnant at ti		Ectopic pregnancy Other (specify)				Day Year
P.0	that the deed by the detached	Phys	9 ☐ Unknown 9☐ Unknown						
	w requires that been signed be should be det	by	Part II. Other significant conditions contributing to death but	not resulting in the ur	iderlying cause give	en in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
Records,	v requ	etec							
Re	he lay e has	Completed					24a. Was an autopsy performed?	prior to con death?	psy findings available appletion of cause of
Vital	ysician: The is certificate hadirector, page	Ø	25. Was case referred to medical			26. Place of Death (C	1 ☐ Yes 2 ☑1	No 1 □ Yes	2( <b>b</b> No
of V	hysica this ce al direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatien		1 3 □ DOA Othe			6 ☐Other (Specify	)
o uc	ding Ph h. After th funeral	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day	Year) 28b. Time of Injury	28c. Injury Work		I. Describe how in	jury occurred	
Division	r Attendi er death. ractor: A by the fu	licat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injur	y - At home, farm, stre		Yes 2 □No	Location (Street	and Number or Rural	Pouto Mumbos
Div	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	4 Homicide determined 206. Place of injurbuilding, etc.	(Specify)	ot, lactory, office		City or Town, Sta	ate)	TIODIG TABILIDET,
	To tha Hospital or within 24 hours after To the Funerel Dit completely filled in		29a. Certifier 1 Certifying Physician: To the best of (Check only 2 Medical Examiner: On the basis of e	my knowledge, death	occurred at the tim	ne, date and place, and	due to the cause	(s) and manner as sta	ited.
	thin 24 thin 24 the F	Medical	one) and manner state 29b. Signature and title of certifier.	ed.	29c. License			Date signed (Month, D	
	7. <u>№</u> 7. 8		▶ 600 1 DO 2 DE	,					,
	3		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, I	#006		Dec	conter of	, 200+
			Elliot Share Do 201		niversity f	Partway B	sallimore,	maryland	21219
:	Sta		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	1 .	,		,	
1	Registr	ar	DEC 0 7 2004 Sener	a p	sparks				

Ferdinand Byas 04-07771 RPD

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			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F <i>rtificate of</i>			giene	J U 4	38583
Phy	sicia		Decedent's Name (First, Middle, La			2		2. Date of Dea	th		3. Time of Death
/M	edica	ıl -	FERDINI 4a. Facility Name (If not institution, give			DYAS		Decembe			04:00A M
Exa	ımine	r	University Hospit			Baltimor	or Location of Dea	atn	40.	County of Dea	/ A
Fune Direc			5. Social Security Number  248-17-5827  Usual Residence of Decedent	ex 7. Age	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		/ Year)		rthplace (State or Foreign ountry) UTH OAROUN
aryland show	1		10a. State 10b. County	,	10c. City, Town or L	ocation					10d. Inside City Limits
the Ma	Tallian .	Director	MARYLAND N	14			TIMO		17	4	1,⊠Yes 2 □ No
death with the Maryland ms 23e or 28e-f show	1		10e. Sfreet and Number	NTALOUST	2 ND FECO		2121	16		i≱en of What C	A.
036 ours after		by rur	11. Marital Status  1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- erto Rican, etc.)		14. Race - Am Black, Whi	
72		erec	15. Decedent's E (Specify only highest gra	fucation de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b. Ki	nd of Business	/Industry
laryland 21215-0 2 should be filed within 72 hi and Mental Hygiene. and marked other than 'natu		Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ONTE		ANER	MA	TROK	CANY MIX
		De	17. Father's Name (First, Middle, Last		n			ame (First, Middle,			Energina
Maryland d 2 should be file th and Mental Hy 7 is marked oth	F	0	19a. Informant's Name/Relationship (	Tuna Print)	10 y A	S	MAI	Rural Route Number	IN	LE	mon
≥ 5 ± 5 ± 5			WERRY BUAS	BROTHE	(50 Main	MT 4	and Number of F	1 BA	r, City o	r Town, State,	Zip Code)
Ore, N		-	20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐	Domount from State	20b. Place of Dispo cemetery, cre	sition (Name of matory or other place	(e)	Date	20c. Lo	cation - City or	Town, State
E a a a s			`4 ☐ Donation 5 ☐ Other (Special	y)		ATHEDA	RAL 12.	-09-04	3	ALTIMO	ORE, MO.
Baltim permit. Pa Department Importants	ODC .		21. Signature of Funeral Service Licer	1/1, ),00	linno 3	2. Name and Addre	ss of Facility	BROW.	JU	TR. Fu.	WERAL HOM
		1	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not en	ter the mode of dyin	g, such as cardia	ac or respiratory arr	KOR est,	210,19	Approximate
Puysici	an		Immediate Cause (Final disease or condition	Head	and che	1 1 "	ries				Interval Between Onset and Death
/Medic Examin	_		resulting in death)	Due to (or as a	consequence of):	1					
	-	2	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):						
cuted		-	lligi illiligied events	C							
58760, icate be executed physician and site be build-transit			resulting in death) Last	Due to (or as a	consequence of):						
68760, ificate be ex	1	ealcal		d							
I Records, P.O. Box 68760, The law requires that the death certificate be executate has been signed by the attending physician and page 2 should be detached for use as the burial-transpace 2.	Jan Join	5	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal death 3 ☐	Ectopic pregnancy Other (specify)			2	23d. Date of de Month	ivery Day Year
S, P is that med b	by D	7	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause givi	en in Part I.	23e. Did tob	pacco u	se contribute to	the cause of death?
ord; equire	100							1 □ Y€	s 25	<b>(</b> No 3□Pr	obably 4 Unknown
Vital Records, striction: The law requires to scentificate has been signed inector, page 2 should be continued.		adillos .						24a. Was a autops perform	y ned?	24b. Were au prior to death? 1 <b>X</b> Yes	itopsy findings available completion of cause of 2 \sum No
Vita sicient s certification	a	2	25. Was case referred to medical examiner? 1 ⚠ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatier	. 21 DOA Othe		ath (Check only on			
on of ding Physical After this funeral dia	F		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of	21		Home 5 Reside			
SIOT tendir eath. tor: Af	i to	Call	1 □Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	12/3/04	3:30	M 1□	Yes 2 No	Subject fo	4 4	urits an	altereativa
Division of Vital Ra To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Cortification		3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		City or Town	, State)	1140 Nor.	iral Route Number, th Blatalou +
ospita hours uneral	700		29a. Certifier 1 Certifying Ph	ysicien: To the best of	my knowledge, death	occurred at the tim	ne, date and place	Striet , Ball e, and due to the ca	uso(s)	and mannar as	stated.
the H hin 24 the Fi	Modical			iner: On the basis of e and manner state	examination and/or in						
Twith Too			29b. Signature and title of certifier	al Al	_	O.C.M.				signed (Mo <i>nti</i> ber 3,	
1		-	30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type.						
0			30. Name and address of person who ZABILICLA			Penn Sti	ceet, Ba	Itimore,	Mar	yland 2	1201
	State istrai		31. Date filed (Month, Day, Year) DEC 0 7 200	32. Registrar	's Signature	-	, <b>H</b>				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie Pe 1 [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** BARBOSA 1421 PM ERNEST DECEMBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NORTH WEST HOSPITAL MORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 07, . Social Security Number 092–32–7189 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 12 M 2□ F Yrs. 62 Puerto Rico Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show s 23a or 28e-f shov MD Baltimore Baltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8349 Mindale Circle 21244 United States death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 3 any injury or other treumatic event, the Medical Examinating ODE. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1X Yes 2 No Specify: Puerto Rican þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Correctional Officer Department Corrections 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barbosa Rosa Maria Martorell Ernesto 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8349 Mindale Circle, Baltimore, Maryland Barbosa (Spouse) 21244 Carolyn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 MCremation 3 Removal from State Baltimore-Washington Crem. 12/06/04 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days disease or condition Sense /Medical resulting in death) Due to (or as a consequence of). Examiner 15 minutes Cardio pulmonan arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): physician and the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending p USB as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 22 No certificate 1 Yes 2 No 1 Yes or Attending Physician: ector, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident after death 6 Could not be determined 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funerel I Fo the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar

6

31. Date filed (Month, Day, Year) DEC 07 2004

Christm

WATSON

29b. Signature and title of certifier

DEBERAH

NORTHWEST 32. Registrar's Signature ze u

MD

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Beker

MOSPITAL

29c. License number

D 0059736

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29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiere 0 0 1 38586 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ANNA MAY BORLITE 11.55 12 5 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1–31–1915 Birthplace (State or Foreign Country) **Funeral** Days 1□M 2XF 174-16-1306 Director OKLAHOMA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If Item 27 Is marked other than "natural", or Items 23e or 28e-f show or other traumatic event, the Medical Examiner must be notified at BALTIMORE ROSEDALE MD 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8006 PHILADELPHIA ROAD 21237 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: If Yes, Give Year or Dates: Specify: WHITE 3
☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental JACOB KRATZEN MARY (KUCHALA) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If ttem 27 la eny injury or other trac once. STANLEY L. BORLIE, JR./ SON 4210 FITCH AVENUE BALTIMORE, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages Burial 2 ☐ Cremation 3 ☐ Removal from State 12-9-2004 4 ☐ Donation 5 ☐ Other (Specify) CARDENS OF FAITH CEM. BALTIMORE, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD Tart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHF **Physician** EXACERBATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy to in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 99 ACUTE RENAL FAILURE, COPD, ATRIAL FIBRILLATION. 1 Yes 2 X No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 🗌 No 1 Yes 2 No rector, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 

Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a filled Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title-of cert D 56477 12-5-2004 address of person who completed cause if death (Item 23a) (Type, Print) , 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD21237 GLENN MEININ GER 32. Resistrar's Signature 31. Date filed (Month, Day, Year) DEC 0 State 7 2004

DHMH 17 Rev 1/2001

Registrar

Box 68760,

P.0.

	•	E _ State	aryland /	Depa	rtment of Health	and Me			38587
		1. Decedent's Name (First, Middle, Last)			inoute of Bout		Reg.		3. Time of Death
Physicia /Medic		Robert WEBSter	Bai	MA	25	D	Month Cember	Day Yeer 4, 2004	11:40 PM
Examin	er	4a. Facility Name (If not institution, give street and number)  Maruland Ceneral Hospita	U		Ba Himpre	of Death		4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Sex 7. Ag. 217-40-0844 12 M 2 F	e (In yrs. last b	Yrs.	Months Days Hours		Date of Birth (Month, Day, Ye	9. Birth Co 143 MA	hplace (State or Foreign untry)  Ay   And
rland ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tox	wn or Loc	cation				10d. Inside City Limits
with the Maryland a or 28e-f show	Director	MARYLAND	B	927	imoRE				1 Yes 2 No
with th		4225 St. VINCENTS	DRIV	15	10f. Zip Code 2/2/	5		Citizen of What Co	
r death	Funerai	11. Marital Status 12. Was Decedent Armed Forces?		13. W	Vas Decedent of Hispanic C Yes, specify Cuban, Mexic	Origin? (Specif	y Yes or No- an, etc.)	14. Race - Ame Black, White	
hours after death with the Maryland hours after death with the Maryland ture!, or frems 23a or 28e-1 show at Example 1 at 1	þ	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates:	10		☐ Yes 2 No Specif			Specify: 8	
"natu	ietec	15. Decedent's Education (Specify only highest grade completed)	168	(Give I	ent's Usual Occupation kind of work done during mo O NOT use retired)	ost of working	161	o. Kind of Business/	Industry
filed within 72 Hygiene. Sther than "nei ent, Its Wedle	Completed	Elementary/Secondary (0-12) College (1-4or 5	+) G	-2	INDS/Keep	eR	1	ANdSCAP	NG
od all	Be	17. Father's Name (First, Middle, Last)					irst, Middle, Mai	•	
s 1 and 2 should by f Health and Menta item 27 is marked other treumatic e	은	Gevrge BARNES  19a. Informant's Name/Relationship (Type, Print)	<u>1</u> 9	9b. Mailin	g Address (Street and Num			-	Tip Code) 2/2/5
and 2 seath ar n 27 is		Christine BARNES- W.		225		NTS 2	R. BA	LTimoRe	md.
permit. Pages 1 and 3 Department of Health Importent: If item 27 any Injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemete	tery, crem	atory or other place)	121	/	Location - City or	rown, State
permit. Pages Department of Importent: If it any Injury or once.		* 4 □ Donation * 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Metro		Rematory Inc	ility The	DERRIC	K C.	MARYLAND
a garaga		Den't d. &		101	611 PARK H	ats. A	ve., BA	110, ma	
		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause of each line.	the death. Do	o not ente	or the mode of dying, such	s cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
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Examiner		Sequentially list conditions b. End 3	ragon	Rer	al Diseas	e			
led nsit	niner	if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence	e of):					
be executed sician and burial-transit	Examin		a consequence	e of):					
cate be physicia the bur	dicai	d.							
	/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		7				23d. Date of deli	verv
The law requires that the death certification has been signed by the attending bage 2 should be detached for use as	Physician/Me	in the past 12 months?  1 Yes 2 No  4 Pregnant at			Ectopic pregnancy Other (specify)			Month	Day Year
that the de led by the a		9 ☐ Unknown  Part II. Other significant conditions contributing to death b	ut not resulting	in the un	derlying cause given in Pari	11	23e Did tobac	co use contribute to	the cause of death?
uires than signed	d by	Takin did diginal di		, 117 010 017	oonlying oddoo givon iii / aii		1 □ Yes		
law requir as been si 2 should	Completed						24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
	Com						performed	l?_ death?	2□ No
Physicien: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2  Two Hospital: 1  Two paties	20586	2			Check only one)	A F1011	
ig Phys ter this o	H- 1	27. Manner of Death 28a. Date of Inju	ry 28b.	. Time of Injury	3 DOA 4 N	Nursing Home 28c	5 🔲 Hesidence I. Describe how i	e 6 □Other (Speci njury occurred	nty)
tendin leath. tor: Aft the fur	catio	2 Accident investigation			M 1 Yes 2				
al or At s after o	Certification:	4 Homicide determined 28e. Place of Injury	ity - At home, to. (Specify)	tam, stre	et, factory, office	281	City or Town, S	t and Number or Ru tate)	ral Houte Number,
To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the	edicai (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of the part of the pa	examination a						
To the To the Comple	Me	29b. Signature and title of cegifier	11 0		29c. License number	r	29d.	Date signed (Month	, Day, Year)
1		Mis Shafile 1	$\mathcal{U}$ . $\mathcal{U}$ .		8950	0 (	1	2-4-04	
H		30. Name and address of person who completed cause of d	eath (Item 23a)	Type, F	(TONOCA)	Haspit	1		
Sta		31. Date filed (Month, Day, Year) 32. Registr.	ar's Signature	9 100 10	· Valerm	Harri	V.	******	
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DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38588 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** December Marie Burk 1 2004 8:45 AM Hazel /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-20-1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2⊠ F Days Yrs. 216-18-6594 88 Director Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylend Depentment of Health and Mental Hygiena. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f ahow any injury or other traumetic event the second or items 23a or 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Odenton Anne Arundel Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 461 Oakton Road 21113 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 white Specify: Be Completed by 3 Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Home maker Home Owner 8 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hattie Lowman John Hood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Neme/Relationship (Type, Print) Mr. Kenneth Burk/son 461 Oakton Rd., Odenton MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 12/6/04 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee M01364 1 Second Ave Sw Glen Burnie MD 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical vece Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Last cate has been signed by the a page 2 should be detached it Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 40 1 ☐ Yes 2 ☐ No ours aftar daath.

•••• Director: After this certificate I fillad in by the funerel director, pag polar 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) PI No edicai Certification: To 2 ER/Outpatient 3 DOA 1 Yes 27. Mann of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

8199 Ritchie
32. Registrar's Signature

Paredena Mayland 21122

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Amend Items 26,29c,d,3 State of Maryland, Department of Health and Mental Hygiene 38589 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 16, 2004 Charles Baughman 12:20 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Devlin Manor Nursing Home Allegany Cumberland If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months Hours 1⊠M 2□ F 80 Yrs. 220-01-4454 Feb 23, 1924 Director Maryland Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, The Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 ☐ Yes 2 🔀 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10301 Christy Road 21502 Funeral USA 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3altimore, Maryland 21215-0020 Specify: white δ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) electrician electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Elmer Baughman Ruth Gertrude Beard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Devlin Manor Nursing Home 10301 Christy Road Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald) S. Wade Mrector Baltimore, MD 21201 25a. Part). Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of). Examiner the attending physician and ched for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) resulting in death) Last page 2 should be deteched Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed ģ Completed 24b. Were autopsy findings 24a. Was an autopsy this certificate has been available prior to completion of cause of death? 1 Yes X No 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4KWursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 🙀 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours et To the Funeral D Medical 1 🔂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060478 December 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Afaq Ahmad,M.D., 625 Kent Ave., Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sports Registrar

**DHMH 16 Rev 6/95** 

#36,296-01,30

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Month **Physician** Year Buwalda, Sr. John December 5, 2004 10:20 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8800 Walther Blvd., Apt. 3513 Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 2 MM 2 □ F 72 Yrs. 480-50-5972 Director Holland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic ayant, the Medical Examiner must be putilised at 1 □Yes 2 □ No Directo MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural; or Items 23s of any injury or other traumatic avant, the Medical Exam as any injury or other traumatic avant, the Medical Exam as any ingus. 8800 Walther Blvd., 21234 Apt. 3513 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 28 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Westinghouse College (1-4or 5+) Elementary/Secondary (0-12) Material Expeditor 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Buwalda Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Buwalda, Jr./Son 2027 Maria Court, Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Dec 1 Burial 2 Cremation 3 Removal from State Beltsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation and Funeral Alternatives NO0986 Mili 8717 Green Pastures Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Holenocarcinoma disease or condition resulting in death) 6 years /Medical Due to (or as a consequence of). Examiner more retrac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the attending physician and ned for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pulmonary Disease hronic Obstructive 1 Yes 2 No Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 1 Yes 2 No 1 TYAS To the Hospital or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes 25 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 15 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*\* Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Kroadway 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State of Registrar		artment of Health and rtificate of Death	Mental Hygie	2004 (	38591
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  John Balog  4a Facility Name (If not institution characters and out	mhar)	4b. City, Town, or Location of De	2. Date of Death Decembe		3. Time of Death  3.18 A M
	Examin	er	4a. Facility Name (If not institution, give street and number Hospital Geven S. Social Security Number 6. Sex	The state of the s	Bouthmere  If Under 1 Year   If Under 24 Hi		4c. County of Death	lace (State or Foreign
	Funeral Director		302-12-1415    √ M 2 □ F  Usual Residence of Decedent	79 Yrs.	Months Days Hours Mi		1925   Ohio	
	a-f show	ctor	Md. 10b. County n/a	10c. City, Town or Lo			1	0d. Inside City Limits 1   Yes 2   No
	death with the Maryland rms 23a or 28a-f show r must be notified at	ai Dire	10e. Street and Number 1700 William Street		10f. Zip Code 21230	10g	. Citizen of What Coun	try?
920	ours after al', or ite	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Nicolar Married 2 Married  12. Was Dec	2 □ No ve	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
21215-0036	"netu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (	(Give life. 1-4or 5+) Mair	dent's Usual Occupation kind of work done during most of w DO NOT use retired) TENANCE	orking	b. Kind of Business/Inc laryland Cu	,
Maryland 2	2 should be filled within and Mental Hygiene. is marked other then eumatic event, the Ms	To Be C	17. Father's Name (First, Middle, Last)	nown		ame <i>(First, Middle, M</i> a. known	iden Sumame)	
	and 2 sho laith and 127 is ma er treums		19a. Informant's Name/Relationship (Type, Print) Thomas Gunther (Step—s		ng Address <i>(Street and Number or I</i> Villiam Street, I			Code)
Baltimore,	Pages 1 am nent of Heal int: If item 2 iry or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from  4 ☐ Donation 5 ☐ Other (Specify)	State	esition (Name of natory or other place)  Crematory 12,		c. Location - City or To Baltimore,	
Balti	permit. Pages. Department of H Importent: If ite eny injury or of once.		21. Signature of Funeral Service Licensee	line	Name and Address of Facility McCully-Polynia 130 E. Fort Ave	ak Funeral e. Baltimor	Home P.A. e, Md. 212	30
	Physician		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	caused the death. Do not ent				Approximate Interval Between Onset and Death
68760,	requires that the death certificate be executed  seen signed by the attending physician and rould be detached for use as the buriat-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):  (or as a consequence of):  (or as a consequence of):	1 Heart fai	lure	1	1,27,04
.O. Box (	that the death certifical ed by the attending phy detached for use as th	Physician/Me	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
Д.	v requires that the been signed by should be detact	by	Part II. Other significant conditions contributing to a Acute Renal Failur	leath but not resulting in the u	nderlying cause given in Part I.		cco use contribute to th	
Il Records,	The law ate has b page 2 si	Completed	Chronic Obstructive p	ulmonary dis	ease	24a. Was an autopsy performer	prior to condeath?	osy findings available inpletion of cause of
f Vita	Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑	npatient 2 ER/Outpatier	Othor	eath (Check only one) Home 5 Residence	e 6 □Other (Specify	')
Division of Vital	ftel		27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	of Injury oth, Day Year) 28b. Time of Injury	f 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
Divis	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, str ling, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rura. State)	Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edicai (	(Check only 2 Medical Examiner: On the b	e best of my knowledge, death pasis of examination and/or in tiner stated.	h occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stand place, and due to	ated. the cause(s)
	To the virthing comp	×	29b. Signature and title of contifier  North		29c. License number P 17341		2 1 5, 200	
	191		30. Name and address of person who completed cau  Dinke Norganov		Ospital Center;	Baltimor	CIM CY	
1	Sta Registi		31. Date filed (Month, Day, Year) 32. F DEC 0 7 2004	Registrar's Signature	Son V			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	l / Depa <i>Cei</i>	artment of H tificate of I	lealth and M Death	ental Hygie		38592
	Physic	an	1. Decedent's Name (First, Middle, Last	3				2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir	cal	4a. Facility Name (If not institution, give	Street and number)		4b. City. Town, or	Location of Death	12 3	200 4 4c. County of Deat	1 Z38 PM
	Examil	iei	University a Ma	anjand		Baltin	NV2		N /	Δ
	Funeral		5. Social Security Number 6. Se	M 2NE	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Co	thplace (State or Foreign buntry)
	Director		212-48-0005 Usual Residence of Decedent	57				Feb. 19,1	947   Ma:	ryland
	arylan show	ž	10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	tha M	Directo	Maryland N/A  10e. Street and Number	Ba	altimo	10f. Zip Code		10a	Citizen of What Co	
	th with 23a or		1531 Covington Stre	eet			1230		U.S.A.	anny.
	er dea Itams	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Itams 23a or 28a-f show avent, the Medical Everther matter motified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:		I□Yes 2⊠No	Specify:		Specify: Wh	nite
21215-0036	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	lent's Usual Occupa	during most of working	16b	. Kind of Business/	
121	filed within Hygiene. othar than "	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired emaker	) -		Own Home	
nd	ba filed tal Hygie d othar avant, II	BeC	17. Father's Name (First, Middle, Last)	±	HOINE	maker	18. Mother's Name	(First, Middle, Maid		
Maryland	should ba nd Mental markad o	70	Carroll		anus		Margaret	Doroth		Carper
Mai	B S S		19a. Informant's Name/Relationship (Ty Roger W. Bowman, S				n Street 1			
ore,	ges 1 and 2 tof Health If itam 27 or other tra		20a. Method of Disposition  1 Ma Burial 2 Cremation 3 F	20b. Pla	ce of Dispo	sition (Name of natory or other place	D		Location - City or	
Baltimore,	permit. Pages Department of I Important: If its any injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Mead		lge Mem. 1			kridge, N	Maryland
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	Min	$M_{\rm c}^{22}$	. Name and Address .Cully-Po. 30 East Fo	is of Facility Lyniak Fur ort Ave. ]	neral Hom Baltimore	e, P.A. . Marvlar	nd 21230
г			23a. Parte. Enter the disease, or compl shock, or heart failure. List only of	ications that caused the death. ne cause on each line.	Do not ente	er the mode of dying	g, such as cardiac or	respiratory arrest,	, , , , , ,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Aortic ]	DISS	ection				Criset and Death
П	Examiner		Conventially list and distance	Due to (or as a conseque	ence of):					
	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a conseque	nce of):					
,	ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					
68760,	ate be hysicia he bur	edical		d						
			IF FEMALE:	3c. If yes, outcome of pregnance	216					
. Box	death certific e attending p od for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.0	that the de led by the a detached i	Phys	9 ☐ Unknowh	9□ Unknown						
	ed be	by	Part II. Other significant conditions con	ntributing to death but not result	ing in the ur	iderlying cause give	n in Part I.	23e. Did tobacc	_	the cause of death?
COL	law requir as been si 2 should	ompleted						24a. Was an		topsy findings available
Vital Records,	The ate h page	Comp						autopsy performed	prior to c death?	completion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	dospital:		Otho	26. Place of Death	(Check only one)		
of	ig Phys ter this neral di	n: To	27. Manper of Leath	28a. Vate of Injury 2	R/Outpatien 8b. Time of	28c. Injury Work	at 2 Nursing Hom	e 5 Residence 8d. Describe how in	6 ☐Other (Speci jury occurred	ity)
sion	Attending r death. actor: After by the fune	atlo	1 Natural 5 Pending investigation	Month, Day Year)	Injury		? ′es 2□No			
Division	or Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office	2	8f. Location (Street City or Town, Sta		ral Route Number,
	Hospital	dical C	29a. Certifier 1 Certifying Phys	sician: To the best of my knowl	edge, death	occurred at the tim	e, date and place, a	nd due to the cause	(s) and manner as	stated.
	To tha Ho within 24 To tha Fu completed	Medic	Ulle)	ner: On the basis of examinatio and manner stated.	n and/or inv					
	5 will	-	29b. Signature and title of certifier	wenter		29c. License P186		29d. [	Date signed (Month	, Day, Year)
١	10		30. Name and address of person who co		3a) (Type, F	Print)		10	12/1	,
	W		Ana S Fren	. 0 22 500		eene St.	, Baltimor	e, Md. 2	1201	
·	Sta Registr	_	31. Date filed (Month, Day, Year)  DEC 0.7 2004	32. Registrar's Signatur	1	parker				

	1 - For State Registrar	State of Maryland / Departm  Certific	ent of Health and Me cate of Death	ental Hygien	
Physician	1. Decedent's Name (First, Middle, Las	D. Ruckley	2	Date of Death Month Day	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give	ostreet and number) #A404 4b. C	Bathmore		County of Death
Funeral Director	Ta1-24-2176	ex 7. Age (In yrs. last birthday) If U Mon	nder 1 Year   f Under 24 Hrs.   8 ths Days Hours Min.	Date of Birth (Month, Day, Year)	9. (Birthplace (State or Foreign Mountry)
Maryland f show	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Location	1050		10d. Inside City Limits 1 XYes 2 □ No
with the Mar 3a or 28a-f sl 1 be natified	10e. Street and Number	HAHOY 10H	Zip Code	10g. Cit	izen of What Country?
72 hours after death with the Maryland neture!; or Itams 23a or 28a-f show that Learning in ust be notified a seed by Funeral Director	11. Marital Status  1 Never Married 2 Married	Armed Forces? If Yes, 1 ☐ Yes 2 N No	ecedent of Hispanic Origin? (Speci specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
72 hours a neturel, o	3 Niwidowed 4 □ Divorced  15. Decedent's Ec (Specify only highest gra	Year or Dates:  lucation 16a. Decedent's	es 2 A. No Specify:  Usual Occupation If work done during most of working	16b. K	Specify: Black ind of Business/Industry
ed within 72 ho ygiene. her than "netur it, the Medical I	Elementary/Secondary (0-12)	College (1-4or 5+)	Tactor	Hoi	ne Improvement
should be filed within and Mental Hygiene. Imarked other than "marked other than "matic event, the Mental Men	17. Father's Name (First, Middle, Last)  Sam  19a. Informant's Name/Relationship (	Type, Printy (daughter) 19b. Mailing Add	18. Mother's Name (i	a Ma	lloy
1 and 2 s Health an tem 27 is other traus	MS Jackie F	Buckley 6402	97th yenue	Seal	ocation - City or Town, State
permit. Pages 1 and 2 should be filed within 72 ho Opparment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department If item 27 is marked other than "neture eny injury or other traumatic event, the Medical once.  To Be Completed	1  Burial 2  Cremation 3	Buckley	emetery /2/10/	2004 Mt.	Hebron, Mississiff
permit. Depart Import eny inj	23a. Parl   Enter the disease, or com	olications that called the death. Do not enter the	LW North Ave. mode of dying, such as cardiac or n		Md. 2/2/6 Approximate Interval Between
Physician /Medical	shack, or heart fail vie. List only Immedia. Cause (Final disease or condition resulting in death)	a. Prostate C  Due to (or as a consequence of):	ancer		Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):			
cate be executed physician and the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
eat cate	IF FEMALE:	d.			
The law requires that the death certificate has been signed by the attending sage 2 should be detached for use as completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy    Live birth   2   Fetal death   3   Ectop  4   Pregnant at time of death   5   Othe  9   Unknown	oic pregnancy r (specify)		23d. Date of delivery Month Day Year
signed by the aid be detached to be detached to by Physic	Part II. Other significant conditions of	ontributing to death but not resulting in the underlyi	ng cause given in Part I,	23e. Did tobacco u	use contribute to the cause of death?
The taw require cate has been sig- page 2 should b				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
nysician: The Is nis certificate har I director, page 2	25. Was case referred to medical examiner?	Hearital.	26. Place of Death (	1 Yes 2 No	1 ☐ Yes 2 No
ding Physi h. After this of funeral dire	1 ☐ Yes 25 No  27. Manner of Death  1 2 Natural 5 ☐ Pending	Hospital: 1 Inpatient 2 FR/Outpatient 3  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		d. Describe how injur	
Atten er deat ector; by the	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	n M	1 Yes 2 No	f. Location (Street an City or Town, State	d Number or Rural Route Number, )
To the Hospital or within 24 hours afte To the Funerel Discompletely filled in Medical Cert	29a. Certifier Certifying Ph	ysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investiga	rred at the time, date and place, an	d due to the cause(s)	and manner as stated.
o the H ithin 24 o the F omplete	one)  29b. Signature and title of certifier	and manner stated.	20s License number	29d Dat	to simped (Month Day Year)
F 3 F 8	> lums	duo	D29071	12	6/04
9	30. Name and address of person who R. ANANDA KMS	completed cause of death (Item 23a) (Type, Print)	ST #305 LA	TIMADE	- MA 2/201
State Registrar	31. Date filed (Month, Day, Year) DEC 0.7	32. Registrar's Signature	South		6/04 - MD 21201

State of Maryland / Department of Health and Mental Hygien 🔊 🎧 🗓 38594 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav Bobby Carl Cox 12:25 P M December 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Hopkins Bayview Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 8, 1936 **Funeral** 1**⊠**M 2□F 213-32-0947 68 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or then "natural", or items 23a or 28a-f show The Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1013 Hewitt Way U. S. A. Funeral 21205 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Ā Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Warehouse Manager Automotive Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Be Alonzo Cox ို Vergie Bare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m eny injury or other traum <u>once.</u> Robert Carl Cox (Son) 1628 Webster Street, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Baltimore, Maryland 12/6/2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, 1XYes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performe certificate 2 No 1 Tes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 Inpatient 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; / completely filled in by the f & □ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 101 29b. Signature and tip 29d. Date signed/(Month, pay, Year m() 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar 2004

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Betty J. Cerezo 9:41a M Dec 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 832 Middlesex Road Baltimore Essex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Sept. 16, Funeral 9. Birthplace (State or Foreign 6.1931 Kentucky Days 1□ M 2□F Months Hours Min. 217-26-7341 73 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic svent, the Medical Examinar must be notified at 1 Tyes 2 No Director MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 832 Middlesex Road 21221 USA death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 Is marked other than "m Elementary/Secondary (0-12) Restaurant College (1-4or 5+) Waitress 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore R. Dezarn 0 Ada J. Wittenbarger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pernit. Pages 1 and 2 sh Dep. rtment of Health and Important: If item 27 Is m any injury or other treum once. Frank Dezarn / brother 102 Brookston Drive Cranberry PA 16066 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 12 Baltimore MD 06/04 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 evn 23a. Part1. Enter the disease, or completications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (Mas a consequence of) Examiner Esquentiany hat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and defached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Year Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been sig 1 Yes 2 No 3 Probably 4 Unknown Completed 24b! Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has 1 Yes 25 No funeral director, 25. Was case referred to dical 26. Place of Death (Check only one, examiner' Other: 1 Tyes 2 1 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 □ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of 28b. Time of 28d. Describe how injury occurred Certification: After or Attending Injury 1 -Tatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide vithin 24 hours a To the Funerel L Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifler 30 N e and address of person o completed cause of death (Item 23a) (Type, Print) 120 31. Date filed (Mor 32. Registrar's Signature State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Trem 3 per phys 839 1-6-05 Vt. State of Maryland / Department of Health and Mental Hygiere 1 1

38596 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat PM Physician Yeer 7:38 AM 01 2004 Virginia Conroy December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 924 Prestwood Road Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 213-09-9165 1 ☐ M 2 💢 F 88 Director December 18,1915 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Catonsville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 924 Prestwood Road 21228 United States death Funeral 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "natural", or Iter any injury or other traumatic event, the Medical Examinat once. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White Ď ¥X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel J. Neff ပ Hester Virginia Neff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Daniel J. Conroy 924 Prestwood Road, Baltimore, Maryland 21228 20a Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Druid Ridge Cemetery 12/06/04 Pikesville, Md. 21208 \* 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Loring Byers Funeral Directors alma 8728 Liberty Road, Randallstown, Maryland 21133 M00333 23a. Parh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to **Physician** 110 m 2014 2 M /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has t s certificate has lirector, page 2 1 Yes 2 Na To the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2010 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) Director: After the 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANN SOWS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Brew Registrar DEC 0 7 2004

State of Maryland / Department of Health and Mental Hygiegen 38597 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** James E. Carter 2 Decombe 2004 7:22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital **Baltimore** N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**XM 2□ F Days Hours 216-18-0533 82 Yrs. Director Maryland Usual Residence of Decedent the Maryland 10b County 10a State 10c, City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, I've Madical Examinar must be notified at Maryland N/A MYYes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3838 Roland Avenue Apt. 609 21211 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or fram any injury or other traumatic event, the Medical Exemi 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: ð Specify: 3XXWidowed 4 □ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Production Orange Juice Co. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jessie Carter Fannie Gates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommie Jean Derry Friend 3838 Roland Avenue Apt. 1105 Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Pemoval from State Baltimore-Washington 12/04/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland Burgee-Henss-Seitz Funeral Home, 3631 Falls Road BAltimore, MD 21. Signature of uneral Service L Rant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician (FibrillAtion ATTRIAL disease or condition resulting in death) CAN /Medical Due to (or as a consequence of): Examiner Chronic Obstinutive Pulminum Sequentially list conditions, Disense Years cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-tran the attending physician and certificate be exe Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) P.O. δ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 KInpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident Injury 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a Funeral C 29a. Certifier 📆 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 25662 12 - 2 - 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALSO J Mercurius Walker 201 FAST n University Parkway Baltimire imp 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 07 2004

			For State Registrar	State of Maryla	nd / [	Department of F Certificate of	lealth and N <i>Death</i>		gierje Reg. No.	004	38598
	Physicia		1. Decedent's Name (First, Middle, Last	י		Cho	IVIS	2. Date of De Month	Day	3 2004	3. Time of Death 2-238 pm
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give he ohns for 5. Social Security Number 6. Security Number 11.	acines Hos		GA Baft	If Under 24 Hrs.	8. Date of Bird (Month, Da	4c. (	9. Birth	
land	MO T		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Tow	or Location					10d. Inside City Limits
е Магу	sa-f sh	ctor	MARYLAND	E	BALT	IMORE					1 Ŷes 2□No
with th	t berio	Dire	1729 Gwynns FA			10f. Zip Code	13:0		_	en of What Cou	ntry?
d 21215-0036 filed within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show adical Examinator mat be nutilized at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1	J.S.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	1215 dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 1	4. Race - Ameri Black, White,	
<b>21215-0036</b> od within 72 hours aff	natura dical E	eted	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done	durina most of work	king	16b. Kin	nd of Business/Ir	
2121 within	I Hygiene. other than ont, I'm Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	40	ine MAKER	d)		Hou:	Sekeel	0,19
and the	d other	Be	17. Father's Name (First, Middle, Last)	å	1,		18. Mother's Nam	e (First, Middle,	Maiden S	Sumame)	
No order	and Menta Is marked aumatic ev	2	Kubert Chi	4 VIS	19b.	Mailing Address (Street	EFFIE and Number or Run			Town State Zin	n Code)
<b>a</b> _ E	of Health ar litem 27 Is r other trau			BRother  Removal from State  Mc	68 Place of	Disposition (Name of y, crematory or other place	RN Rd.  De) 12/11  INC. 111  ss of Facility The	Denri	20c. Loc BAL CK (	md. 2 cation - City or Timore C. Jone	U1267 own, State MARYIAN d SFIX, P.A.
- I	Medical (saminer substitution)	edicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ilications that bayed the deal ne caus on each line.  a.	quence o	onl enter the mode of dying of the control of the c	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death 2 months
Records, P.O. Box (The law requires that the death certi		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23	3d. Date of delive Month	ery Day Year
ords, P	een signed b hould be deta	þ	Part II. Other significant conditions co	ntribuling to death but not re	sulling in	the underlying cause giv	en in Part I.		obacco us	/	he cause of death?
ital Rec	tificate has b	e Completed	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	sy med2 2 No	prior to co death?	opsy findings available impletion of cause of
Division of Vital Records, To the Hospitel or Attending Physicien: The law requires to	within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To B	examiner?  1 Yes 2 No   27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	Hospital: 1 2 Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	28b. T	ime of 28c. Injury World	er: 4 □ Nursing Ho y at k? Yes 2 □ No	ome 5 Resid 28d. Describe h	lence 6 low injury	occurred	
Divi	urs after o		4 Homicide determined	28e. Place of Injury - Al I building, etc. (Spec	ify)			City or Tow	m, State)		al Route Number,
Hosp	within 24 hours  To the Funerel  completely filled	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn iner: On the basis of examin and manner slated.	owledge ation and	, death occurred at the tin d/or investigation, in my o	ne, date and place, pinion, death occurr	and due to the or red at the time, or	ause(s) a date and p	and manner as s place, and due to	tated. the cause(s)
70 th	To th	E .	29b. Signature and title of certifier	50n f. M.	1).	29c. Licens	e number = S-000		_	signed (Month,	Day, Year) 3, 2004
1	ノ <b>`</b>		30. Name and address of person who co	4, JR. M.D. 6	001	Type, Print) North Wolfe	Street	Raltin	nove	MD 24	287
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 7 200	32. Registrar's Sign	ature						
DHMH	17 Rev 1/20		0 / 200	4 Depera	1	4 Sports	/				and the

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 38599 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Bernice 1015 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital 6. Sex Westminster

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) accoil Carroll Corter 9. Birthplece (State or Foreign Country)

OKLAHOMA If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 X F 87 Yrs. Director 443 09 3206 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show of Health and Mental Hygiene. Item 27 is marked other than "nature!', or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Funeral Director CARROLL mo MANCHESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21102 USA 3332 STREET main 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify. Specify: ģ Whit 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 10 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Locftelholz MARY STOECK HNTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5416 EMERALD DRIVE ELDERSbURG MO 21784 Rick CARRIKER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 JO , Depertment of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Win field, South CARROIL CREMATORY 12/7/2004 22. Name and Address of Facility ZUMBNON 21. Signature of Funeral Service Licenses Zu Sykesville Road ELDERSburg MO 6028 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner be deteched for use as the buriel-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. mentia by Physician/Medical Due to (or as a consequence of) 23b. Did tobacco usa contributa to tha causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No certificete eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Dinpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of After t 5 ☐ Pending 1 Naturel 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funeral C completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certified ၉ 81 who completed cause of death (Item 23e) (Type, Print) 30. Name end address of person Stoner 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar DEC 0 7 2004

		•	For State Registrar	State of Mar		artment of H			200	4 38600
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day `	3. Time of Death
	Physicia /Medic		Robert	David Cu	mmins			December		04 6:00 P M
	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of	
			Fairfield Nursing  5. Social Security Number 6. Sex		(In yrs. last birthday)	Crown If Under 1 Year	sville	8. Date of Birth		Arundel
	Funeral Director			M 2□F	72 Yrs.	Months Days	Hours Min.	(Month, Day, \	1932	9. Birthplace (State or Foreign Country) Pennsylvania
			Usual Residence of Decedent		14			TIMIX Z,	1932	reilisylvania
	show		10a. State 10b. County	1	IOc. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f s	cto	Maryland Anne Art	ındel		Crowns	ville	_,		1 X Yes 2 □ No
	vith th	Director	10e. Street and Number			10f, Zip Code		100	g. Citizen of Wh	nat Country?
	es 23	eral	1454 Fairfield	Loop Reg. Was Decedent Ev		2103 Was Decedent of Hi		acify Vas or No.		SA - American Indian,
10	iter d	Funeral	1 Never Married 2 Married	Armed Forces?		f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		White, etc.
93	ours after death with the Maryla rel', or Items 23a or 28a-1 shov Examiner must be nutified at		3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1	L951-55	I□Yes 2 <b>X</b> No	Specify:		Specify:	White
2-0	72 hours after death with the Maryland reture!, or Items 23s or 28s-1 show dical Examiner must be nuffiled at	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa	during most of work	ing 16	6b. Kind of Bus	iness/Industry
121	within ene. then *	Completed by	Elementary/Secondary (0-12) UNK	College (1-4or 5+)		DO NOT use retired	)		TINTE	
2	filed v Hygie other I		17. Father's Name (First, Middle, Last)		UNK		18. Mother's Name	e (First, Middle, Ma	UNK aiden Surname	)
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours f Health and Mental Hygiene. Item 27 is marked other then "naturel", other treumatic event, the Medical Exa	To Be	UNK				UNK			
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	g Address (Street a	and Number or Run	al Route Number, (	City or Town, S	tate, Zip Code)
	and 2 lealth a m 27 is		Wanda Raleigh/Guare	dian of Pe	erson 266	e Arundel 6 Riva R	county and Suit	Departmer e 400 Ar	nt of A	ging s, MD 21401
ore	<b>0</b> 0 <del>-</del> -	H	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place	θ)	Date 20	Dc. Location - C	ity or Town, State
Ë	nit. Pages vartment of l ortent: If Its injury or or	١,	'4 ☐ Donation 5 ☐ Other (Specify)		Metro Cr				Baltin	more, MD
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If Item any injury or othe		21. Signature of Funeral Service License  Edward A. Grego	1	C 2	Name and Address remation 99 Freder	Society Sick Road	of MD, In Baltimor	nc. ce. MD 2	21228
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused th	ne death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Celon	Carci	nomel				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					0
Н	LAGIIIIICI	-	Sequentially list conditions, b.	One tu for as a r	consequence of):				-	
,	ned I Insit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
Ć	cate be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):					
8760,	ite be iysicia ne bur	dicai	d							
9	artifica ing ph	Med	IF FEMALE:							
Вох	Jeath certifica attending ph for use as th	an/l	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of 1 Live birth 2	☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date Mont	
0.	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	me of death 5	] Other (s <i>pecify)</i>				
Δ.	es that the d igned by the be detached		Part II. Other significent conditions con	ributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	icco use contrib	oute to the cause of death?
of Vital Records,	quires n sign ald be	d by						1 ☐ Yes	2 □ No 3	Probably 4 Unknown
000	sw requir	Completed						24a. Was an	24b. We	ere autopsy findings available
Re	The lav	E O						autopsy performe	ed/2 de	or to completion of cause of ath? ]Yes 2□ No
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	n (Check only one)		
<u>&gt;</u>	X S D	5	1 ☐ Yes 2 🗹 No	ospital: 1			4 Windrsing Ho	me 5□Residen		
n	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	Year) 28b. Time of Injury	Work		28d. Describe how	injury occurred	1
Sio	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury	/ - At home, farm, str		Yes 2 □No	28f Location (Stre	et and Number	or Rural Route Number,
Division	after Direct	Certification;	4 Homicide determined	building, etc.	(Specify)	eet, lactory, office		City or Town,	State)	or ridiar ridule reambor,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical C	29a. Certifier (Check only one)	ician: To the best of er: On the basis of e and manner state	xamination and/or in-	occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, date	ise(s) and mani e and place, an	ner as stated. d due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	len	MD	29c. License	number 10519			(Month, Day, Year)
	į		30. Name and address of person who con	noleted cause of de-	th (Item 22a) /T		/	E	ecember	4, 2004
	/		1) IR ZIA M NUS		(140) (Type,	APISON	PARK	GLEN	V Burnie	no.
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar						
	Registr	ar i	DEC 0 7 2004	Benure	1 /9	Sound.				
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 38601 Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Florence Cox DEPENSOR /Medical 5004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Geroge's Doctor's Community Hospital Lanham
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 29,1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Months Days Hours 80 Yrs. Director 007-16-0340 Maine Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 🋠 🛱 No Maryland Director Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6620 Washington Blvd. #9 21075 United States by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tes 2 No Specify: Specify: White 3XXWidowed 4 ☐ Divorced 2 should be filed within 72 hours and Mental Hygiene.
Is marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Forrest Kelley Opal Pierce 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 is m any injury or other treum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelley Cox / Son 6376 Norris St., Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State `4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 12/7/04 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring,MD 2 The Johnmann M00382 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician EMBOLISM disease or condition resulting in death) 4-04 DULHONARY /Medical Due to (or as a consequence of): Examiner RCINOMA OESOPHAGUS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit EE Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4⊡Pregnant at time of death 5 ☐ Other (specify) the Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 No 1☐ Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification; 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO013668 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLLEGE PARK MD 20740 4917 EDGELDOOD RO HUSSAIN M.S 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 7 2004 Registrar

MAN			1- For Unpend Item 23a,27,28a-f per me G838 12-8-04 ta Certificate of Death	Mental Hy s	gieze 0	4 38602
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  LARRY RUSSell Christy	2. Date of De Month Novemb	Day	3. Time of Death 2004 1930 P M
	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	ath	4c. County	
8	Funeral		1875 Brookside Drive Edgewood  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I funder 24 Hr		Harf	
2	Director		218-78-7578 12M 2DF 38 Yrs. Months Days Hours Mir	JANUA	y, Year)	Birthplace (State or Foreign Country)
7 _	show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryland a-f show	ctor	MU HARFORD Edgewood			1 XYes 2 □ No
	or 28	Funeral Director	10e. Street and Number		10g. Citizen of W	hat Country?
	eath v	erai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Specify Ves or No	14 Bace	- American Indian,
Baltimore, Maryland 21215-0036	72 hours attar death with the Maryla "natural", or Items 23a or 28a-1 shov dical Examirer must be notified at	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer of Dates)  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer of Dates)  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer of Dates)	rto Rican, etc.)	Black Specify:	K, White, etc.
5-0		eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of will life. DO NOT use retired)	orking	16b. Kind of Bu	siness/Industry
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nd 2	2 should be filed within and Mental Hygiene. Is markad other than aumatic event, Its Ma	BeC		ame (First, Middle	, Maiden Sumam	9)
yaı	ould b Menta narkad natic •	To	Julian Christy Oneic	da Pi	HOOKS	5
Z a	and 2 sh salth and n 27 Is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F	Rural Route Numb	er, City or Town, s	State, Zip Code)
re,	of Hea item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		City or Town, State
Ē	Page ment c ant: If ury or		1 Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Creen included Ceman Dec	1,2004	Baltimor	e, MD
Balt	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than eny Injury or other traumatic event. If a More.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility			C+ JOPAN MI)
	-		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.			Ap roximate
	Pnysician		Immediate Cause (Final disease or condition Narcotic (heroin) intoxication			Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate cause. First lindarying Cause (Disease or Injury.			
	cuted nd ransit	Examiner	that initiated events C.			
60,	icate be executed physician and the burial-transit	i Ex	resulting in death) Last Due to (or as a consequence of):			
68760,	ificate be executed g physician and as the burial-transi	edicai	d			
.O. Box	attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date Mon	e of delivery th Day Year
Ω.	w requires that the deben signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contri	bute to the cause of death?
ords	equire sen sig ould b			1 🗆 '	Yes 2□No	3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	<i>(0)</i> ← <i>L</i>	Completed			osy pr	Vere autopsy findings available rior to completion of cause of ea.h?
Vita	Physician: Th this certificate ral director, pag	Be	examiner?	eath (Check only o		7.13
of		n: To	27. Manner of Death  28a. Date of Injury  28b. Time of Injury 22c. Injury at		dence 6 <b>X</b> Othe now injury occurre	
ion	Attending r death. actor: After by the fune	atio	2 Accident investigation 11-19-04 M 1 Yes 2X No			dine
) Vis	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 【X Could not be determined  28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (3 City or Tox	Street and Number vn, State) 187	or Rural Route Number, Dr.
	spital ours a ours a naral C		Home  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	Edgewood		oner as stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time,	date and place, a	nd due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier 29c. License number			(Month, Day, Year)
			O.C.M.E.		Novembe	r 20, 2004
			30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Ba	ltimore,	Marylan	d 21201
	Sta		31. Date filed (Month, Day, Year) 332 Registrar's Signature			
	Registr	ar	DEC 0 7 2004 Seem & sparte			

Please Type or Print in	Black Indelible Ink.	<b>Ensure All Copies</b>	Are Legib
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		_1	For State Registrar			OTIMA	aryıan			te of Dea		Mental Hy	Reg. No	U U 4	3860	
Phys /Me	icia: dica	n <sub>F</sub>	1. Decedent's Nam IENRIETTA						2. Date of Death Month				Day	3 200		
Exar		r	la. Facility Name (		give street and	number)				, Town, or Loca	tion of Death		4c. County of Death			
			ERCY HOS			1				IMORE	Index Od Use	T			/A	
Funer Direct			5. Social Security (251 72 23		6. Sex 1 ☐ M 2 ☐ X0			ost birthday	Months		nder 24 Hrs. ours Min.	8. Date of Bir (Month, Da JAN 27	iy, Year)		irthplace (State or Country) CAROLINA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumatic event. If a Medical Examinational be notified at ance.		-	Usual Residence o 10a. State	of Decedent 10b. County		<del></del>	10c, City	, Town or I	ocation				_		10d. Inside Cit	tv Limits
				,	/7									1X Yes 2 □ No		
		Ö  -	10e. Street and Nu		/A		BALI	'IMORE					10a, Cit	izen of What (	Country?	
		5	306 E. EZ		<b>ਫ਼ਾਰ</b> ਜ				21202			,	U.S.A			
Jeath		_	11. Marital Status	GEK SIK	12. Was E	Decedent	Ever in U.	S. 13	. Was Dec	edent of Hispan	ic Origin? (S	pecify Yes or No	)-	14. Race - An	nerican Indian,	
affer of life			1 XNever Mar	ried 2 Marrie	ed 1 □Y	d Forces? es 2⊠i				ecify Cuban, Mi		o Hican, etc.)		Black, Wh	nite, etc.	
hours a	:	D	3 🗆 Widowed	4 Divorced	Year	, Give or Dates:			1 🗌 Yes	Z∐ <b>N</b> o Sp	ecify:			Specify: B	LACK	
72 h		etec	(Spe	15. Decedent		ed)		(Giv	e kind of w	ual Occupation ork done during	most of wor	king	16b. K	ind of Busines	s/Industry	
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d be fill antal Hy ced oth	- 1	m ļ	17. Father's Name (First, Middle, Last)													
thoute and Me mark matic		0	19a. Informant's N		ip (Tvpe, Print)			19b. Ma	lina Addre			ral Route Numb	er. City o	or Town, State	. Zip Code)	
nd 2 st lith and 27 ie r		1	OYCE E.									LTIMORE				
S 1 all		1	20a. Method of Dis	•			20b. P	Lace of Dispendent	osition (N	ame of other place)		Date	20c. Lo	ocation - City o	or Town, State	
Page Bent o nt: If				Cremation 5 ☐ Other (Sp		om State				PARK	DECEN	MBER 9.	2004	ВАТЛО	MARYLA	MD
Definition Pages Department of Mportant: If it in why injury or o	once.		21. Signature of F	uneral Service L	icensee	17			22. Name	and Address of	Facility CZ	LVIN B.	SCR	UGGS F	UNERAL H	OME
0 88E 5	а		Den	rades	red,	AU	Euch	1	412 E	. PREST	ON STR	EET BAL	TIMO	RE, MA	RYLAND 2	1213
Priysicia /Medic			23a. Part1. Enter shock, or he Immediate Cause disease or conditi resulting in death)	art failure. List o (Final on	a	on each li	ne.	140		ode of dying, su		or respiratory a	rrest,		Approximate Interval Betw Onset and D	ween
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te be executed ysician and le burial-transit		20	resulting in death) Last  Due to (or as a consequence of):  d.													
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the death certificate by the attending physic ched for use as the b		Physician/Medic	IF FEMALE: 23b. Was decede in the past 1: 1 ☐ Yes 2 9 ☐ Unknow	2 months?	1 □ Li 4 □ Pi	23c. If yes, outcome of pregnancy  1							23d. Date of d Month		ear ear	
that ithat i		by Ph	Part II. Other sign		ns contributing	to death b	out not res	ulting in the	underlying	cause given in	Part I.				to the cause of de	
w requires been sign should be												10	Yes 2	□No Jacol	Probably 4 DU	Jnknown
The lar		Completed										24a. Was auto perfo 1  Yes	an psy prmed? 2 No	prior to death?		available ause of
vicion: T		Be	25. Was case refe examiner?	/	Hospital:		_					th (Check only				
Phys r this aral dii		tion: To	1 ☐ Yes 2.2 27. Manner of Dea 1 ☐ Natural 2 ☐ Accident		28a. D	I □ Inpatie Pate of Inju Month, Da	ıry	ER/Outpati 28b. Time Injury	of	28c. Injury at Work?		ome 5 Resi 28d. Describe			pecify) has i	ice
ol VISION  let or Attending a after death. I Director: After id in by the function		Certification:	3 Suicide 4 Homicide	6 ☐ Could n determi	ned <00. F	lace of Injuilding, et	jury - At ho c. (Specif	ome, farm, :	street, facto					Street and Number or Rural Route Number, vn, State)		
he Hospit n 24 hours ne Funere		Medical	29a. Certifier (Check only one)	1 Certifying 2 Medical E	xaminer: On the	the best he basis o manner st	of examina	wledge, de tion and/or	ath occurre investigation	d at the time, do	ate and place n, death occu	, and due to the rred at the time,	cause(s)	and manner and di	as stated. ue to the cause(s)	)
To th within To th		Σ	29b. Signature and	d title of certifier	~\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	00			2	9c. License nur	nber SLI		29d. Da	te signed (Mod	nth, Day, Year)	
A			30. Name and add	dress of person	who completed	cause of c	death (Iten	1 23a) (Typ	e, Print)	01 0	oldi.	nore	im c	71	202	
J	1													λ , / '	/ 1/	

			For State	State of Maryland /	Department of Health and N Certificate of Death			38604
			Registrer  1. Decedent's Name (First, Middle, I	Last)	- Continuate of Beatin	Reg. 1		3. Time of Death D
п	Physicia		Wallace	Countell			Day Year Zeo4.	3:07
	/Medic Examin Funeral Director		242-36-0485		4b. City, Town, or Location of Death  Buth York  birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth A (Month, Pay, Yei	4c. County of Death	n hplace (State or Foreign unity)
	and		Usual Residence of Decedent  10a. State 10b. County, i	10c. City, To	own or Location			10d. Inside City Limits
	the Maryls 28a-f sho	ector	Maryland N	A B	altimore	100	Citizen of What Co	1 Yes 2 □ No
	h with	ai Di	501 Dolo	hin St	21217		115	4
98	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentel Hygiene, item 27 is marked other then "naturel", or fitems 23e or 28e-f show other treumetic event, the Medical Examinal must be rediffed at	y Funerai Director	11. Marital Status  1 □ Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 1  Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: 7	
21215-0036	72 hours 'naturel', diesi Exe	eted by	3 Widowed 4 Divorced  15. Decedent's (Specify only highest)	Year or Dates: Education 16	Sa. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b.	. Kind of Business/	Industry
12121	filed within Hygiene. other then "u	Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, La	College (1-4or 5+)	Self-Employe	e (First, Middle, Maid	Bar	Owner
y F	should be filed within nd Mental Hygiene, i marked other then umetic event, the Menuel to the them the metic event, the Menuel to the metic event, the Menuel to the Menue	To Be	James	Campbell			Tisd	ale
e, Mary	s 1 and 2 sho of Health and item 27 is my other treum		19a. Informant's Name/Relationship  MCS Joyce (  20a. Method of Disposition	ampbell 5	9b. Mailing Address (Street and Number or Rur of Disposition (Name of	Ave # Al	42 Balt	D. Md. 21228
altimore,	Page nent c ent: If ury or		1 X Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spe	□Removal from State Cify)	tery, crematory or other place)  10 N  22. Name and Address of Facility	2004 /	unsdou	une, Md.
Bal	permit. Depart Import eny inj		Joseph	L. Kuss	Joseph L. Russ	P. Balto	Home Md. 21	216 Approximate
	Pnysician		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ily one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	/	Interval Between Onset and Death
1	/Medical Examiner			Due to (or as a consequence	ee of):			
	po tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b				
60,	cate be executed physician and the burial-transit	al Examin	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence)	e of):			
	intiticate ing phys a as the	Medical	IF FEMALE:	d				
.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown			23d. Date of deli Month	very Day Year
<b>a</b>	quires that in signed by	by	Part II. Other significant condition  Hyperteur's	s contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacc		the cause of death?
Records,	The law requir cate has been si page 2 should	ompleted	Hypercipida	25n9		24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?			h (Check only one)		
of	Phys rthis raldii	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury 28b	Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence		eify)
ion	ttending f death. ctor: Atter y the funer	atior	1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investiga		Injury Work? M 1 ☐ Yes 2 ☐ No			
Division	el or Attend s after death il Director: , id in by the f	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		farm, street, factory, office	28f. Location (Street City or Town, St		ral Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Atte completely filled in by the fune	edical C	29a. Certifier (Check only one)	Physicien: To the best of my knowled teminer: On the basis of examination and manner stated.	ige, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the vithing To the company of the	ž	29b. Signature and title of certifier	Remark	29c. License number	29d. l	Date signed (Month	
	2		20 Name and address of paragraph	no completed cause of death (the CO)	DIS667		12-02	•
	Sta		30. Name and address of person with the second seco	no completed cause of death (Item 23: Chwartz 32. Registrar's Signature	7310 Ritchie Hi	ghway,5	DB Gle	n Burnie, Ma
	Registi		DEC O.	7 2004 32. Registrar's Signature	12 papares			

State of Maryland / Department of Health and Mental Hygiene 0 0 4 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:15p William Ε. Danesie Dec. 6 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 234 Orville Road Baltimore Essex 8. Date of Birth
(Month, Day, Year)
July25,1931 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F 73 215-<sub>28-7985</sub> Director Maryland Usual Residence of Deceden the Maryland 10a State 10c. City, Town or Location 10d Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ➡ No MD Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23£ or 2 death with USA 234 Orville Road 21221 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) Transportation Truck Driver 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 is marked o Carmine Danesie Elsie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Ward / neice 234 Orville Road Baltimore MD other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. injury or 12/7/04 Baltimore MD Bayview Crematory `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licens 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) I Yes 2 No ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA Certification: To this s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Qay, Year) DIVI 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print)
Helen Simpsm, MO 1245 Eastern Easte 31. Date filed (Month, Day ) 32. Registrar's Signature State 2004 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienen 01.

	•	1 - For State Registrar	State of Ma		epartment o Certificate	f Health and of Death		Reg. No.	004	38606
Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month	Day		3. Time of Death
/Medic		Lorraine Margaret			Ab Cib. Tou	I II I D	Decemb	-		1:39 PM
Examin		4a Facility Name (If not institution, give Manor Care Rossvi.			n, or Location of Dea lossville	ıtn	4C.	4c. County of Death Baltimore		
Funeral Director		5. Social Security Number 6. S 217 16 6220		(In yrs. last birtl	iday) If Under 1 Y			th ly, Year) , 1921		hplace (State or Foreign unitry) yland
and	-	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
Maryli f sho	ţō	Maryland Baltimo	re	F	Ssex					1 ☐ Yes 2X No
n the	lrec	10e. Street and Number			10f. Zip Cod	de		10g. Citiz	zen of What Co	puntry?
th with	aiD	1106 Tace Drive Ap	pt.2A		21	221			USA	
inc.) Intally later Z. E. E. C.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 2 N If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify € 1 □ Yes 2⊠	of Hispanic Origin? (: Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No rto Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.
72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Usual Or Give kind of work do	ccupation one during most of wo tired)	orking	16b. Kir	nd of Business	Industry
within hen hen	mpl	Elementary/Secondary (0-12)	College (1-4or 5-	r)	iife. DO NOT use re Lb Assista			ЦС	ognital	
Hygie ther t	e Co	17. Father's Name (First, Middle, Last)		ша	m ASSISCO		ame (First, Middle		ospital Sumame)	
id be ental ked o	00	John Milton Fick				Edith 1	Mae Stree	et		
should Mind Mind Mind Mind Mind Mind Mind Min		19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Address (St	reet and Number or F	Rural Route Numb	er, City or	Town, State, 2	Zip Code)
and 2 alth a		Georgette Dunevan	t (Daughter	<del>:</del> ) 111	4 Tace Dr	ive Apt. 2	B Baltim	ore,	Md. 21	221
es 1 a		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □	Removal from State	cemetery	Disposition (Name of crematory or other	place)	Date		cation - City or	
permit. Pages 1 Department of H Importent: If its any injury or ot		'4 □Donation 5 □ Other (Specific		Garden	s Of Faitl	n Cemetery	12/8/200	4 Ba.	ltimore	, Maryland
Dermit. Departimport. Import. any inj.		21. Signature of Funeral Service Licer	(See ) ()		22. Name and A	dress of Facility	al Home 1	P. A.		
7 70 7 4 a		John W. Du	require	de de de De e		ski Funera Eastern 2			Md. 2	1221
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each lin	e.	ot enter the mode of	dying, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Myocard:							30 Minutes
Examiner				consequence o scleroti		ascular D	isease			Years
	Jer	Sequentially list conditions, if any, leading to immediate	b	i consaquença o						
cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
e exe	EX	resulting in death) Last	Due to (or as a	consequence o	f):					
ficate be executed physician and sthe burial-transit	dical		d							
ding p	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy					23d. Date of del	ivon/
atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death	3 ☐Ectopic pregn 5 ☐ Other (specifi			-	Month	Day Year
ithe d	hysi	1 ☐ Yes 2 ② No 9 ☐ Unknown	9□ Unknown							
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions of	-	t not resulting in	the underlying cause	given in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
require		Atrial Fibrilla	CION		_		1 🗆	Yes 212	ÖNo 3∏Pr	obably 4 DUnknown
law ri as be	Completed						24a. Was	psv	24b. Were au	topsy findings available completion of cause of
The Tate h page	Con						perfo 1 🗆 Yes	ormed? 2⊠ No	death?	2 🗆 No
On VICAL INC. Physicien: The lav this certificate has al director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Othor	eath (Check only o		1000	
Phys this ral dir	. To	1 ☐ Yes 2 ☒ No  27. Manner of Death	1 Inpatier			4A Industria	Home 5 Resi			cify)
ding Phy h. After thi funeral	tlon	1 ☑Natural 5 ☐ Pending	(Month, Day		jury	njury at Work? 1 ☐ Yes 2 ☐ No	EDG. DOGOTIDO	now injury	00001100	
Attending or death.	ertification:	3 Suicide 6 Could not b	e 28e. Place of Inju	ry - At home, far	m, street, factory, of					ıral Route Number,
s affection of in Direction of in E	Cert	4 Homicide	building, etc	. (Specify)			City or To	wn, State)	,	
ospit hours unere ly fille		29a. Certifier 1∑ Certifying Pt (Check only 2 Medical Exar	ysician: To the best on the basis of	f my knowledge,	death occurred at th	e time, date and place	ce, and due to the	cause(s)	and manner as	stated.
To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical	one)	and manner sta	ted.						
To To	2	29b. Signature and title of certifier	>		29C. LI	ense number		29d, Date	e signed (Mont	, Day, rear)
0			analoted / ·		D-	111472		12	-06-0	4
11)		30. Name and address of person who	completed cause of de		er Blv	d To	uson, M	d	2120	/ -
Sta	te	31. Date filed (Month, Day, Year)		r's Signature	U~ #11	J. 10V	V.S.(1)	<u> </u>	ac 1 010	0
Registr		DEC 0 7 2004	Capena	4	for it					
DHMH 17 Rev 1/2	001		1	1	pyrones					

ORIGINAL

			State of Maryland / Dep	artment of Health and	Mental Hyg	ie2e0 0 1,	38607	
			1 - State Registrar AMEND ITEM #20b PER FH G839 G9  1. Decedent's Name (First, Middle, Last)	rtificate of Death		g. No.		
1	Physici		Albert T Dannie		Decemb	Day Year	3. Time of Death	
I	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Dear		
			Charlotte Hall Veteran's Home	Charlotte Hall		St. Mary's		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 110 M 2 F 78 Yrs.	If Under 1 Year   If Under 24 Hr   Months   Days   Hours   Mir		, 1926 Mar	thplace (State or Foreign ountry) y land	
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits	
	Mary Ind	tor	Maryland St. Mary's Charlotte Ha	111			1 Tyes 2 No	
	or 286	Jirec	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Co	ountry?	
	s 23a	rail	29449 Charlotte Hall Road  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20622	(Coopie Von an No	USA	USA 14. Race - American Indian,	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, it a Modical Examinar must be notified at	y Funerai Director	Armed Forces?  1 □ Never Married 2 □ Married 1 ▼ Yes 2 □ No WHT T	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 ☒ No Specify:	erto Rican, etc.)	Black, Whit	e, etc.	
21212-0036	2 hou	Completed by	15 Decedent's Education 16a Dece	dent's Usual Occupation	ndina	16b. Kind of Business/	/Industry	
	ithin 7 ne. han "r	mpie	Flementary/Secondary (0-12)   College (1-4or 5+)	kind of work done during most of w DO NOT use retired) Information Officer	Orking	Fodous 7. Os		
	filed w Hygier ther tl	CO	17. Father's Name (First, Middle, Last)		ame (First, Middle, N	Federal Gove	ernment	
yland	ed ala	To Be	John Dennis	Lettie G				
Mary	and N and N is mai		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or F	Rural Route Number,	City or Town, State, 2	Zip Code)	
	1 and 2 Health tem 27		The Ima H. Dennis/Ex Wife 5201 20a. Method of Disposition 20b. Place of Dispo	Eugene Avenue Balti	more Marylar	nd 21206 20c. Location - City or	Town Chat-	
000	0 0		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 10 Other (Specify) Entomoment Oaklawn Ce		00/04	Baltimore Mar	,	
Baltimore,	permit. Pagi Department Important; i any injury o			2. Name and Address of Facility Buck Inc. 303 Harford Road Ba			y rai ia	
n =	90 E = 9							
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	12	ac or respiratory arre	SI,	Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)  a	disease				
	Examiner		Sequentially list conditions, b.					
	ed sit	niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury					
,	execut n and iai-trar	Examin	that initiated events c. Due to (or as a consequence of):					
8/60	cate be executed physician and the burial-transit	dicai	d					
٥	ertifica ding ph		IF FEMALE: 23c. If yes, outcome of pregnancy					
X Q Q	death certif e attending od for use as	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deli Month	Day Year	
j.	it the d by the tached	hysi	9 Unknown					
ras, r	<ul> <li>requires that the death certiff</li> <li>been signed by the attending</li> <li>should be detached for use as</li> </ul>	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		23e. Did tobacco use cont. • e to the cause of death?  1 \[ Yes  2 \] 4 \[ \text{o}  3 \[ \] Probably  4 \[ \]Unknown		
ecord	m 9 01	Completed			24a. Was an autopsy	prior to d	topsy findings available completion of cause of	
T E	Th ate pag	Con			perform 1 ☐ Yes 2		2 No	
Vital	Physician: this certific ral director,	o Be	25. Was case referred of medical examiner?  1   Yes   Yes	Other	Bath (Check only one	nce 6 □Other (Spec	note)	
on or	iding Phys th. : After this funeral di	$\vdash$	27. M nn of Death 1 atural 5 Pending 2   Accident investigation   28a. Date of Injury (Month, Day Year)   28b. Time of Injury		28d. Describe how		y)	
UNISION	Atten deal ctor y the	Certification;	3 Suicide 6 Could not be determined 8e. Place of Injury At home, farm, str building, etc. (Specify)	28f. Location (Stre City or Town,	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, deatt 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and plac vestigation, in my opinion, death occ	ce, and due to the car curred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To the To the To the Compl	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month	n, Day, Year)	
			AMMONT	00060	120	12/30	104	
	511		30. Name and address of person who completed cause of death (Item 23a) (Type,	11 - 1 0	4. Pm	no Conedo	inck, MD	
	Sta		31. Date filed (Month, Day, Year) DEC 0.7 2004	Ana V	1 1/200	2067	8	
	Registr	ar	~ CUU4 / /	y vary			0	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28,2004 Month **Physician** Thomas Edward Dennis Navern ber /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠**M 2□F 212-34-4345 Yrs. 68 10, **Director** Jan. 1936 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at Baltimore Maryland N/AXX Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 110 N. Central Avenue #116 21202 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Housing Authority al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Resident Advisory Baltimore City 10th grade Coordinator nt of Health and Mental Hyg If item 27 Is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 Is marked ott Unknown Lillian Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Devron Dennis/ Son 3906 Glenmore Avenue Baltimore, Md 21206 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Druid Ridge Cemetery 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once. Pikesville, Md \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 27975 21. Signature of Funeral Service L censee Much 23a. Part. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** septicemia 72 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician iclan/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) ed by the detached by Physi 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has this certificate 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Impatient Certification: To 28b. Time of Injury 27. Manual of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 / Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number Normbur 28, 2004 AU4176435516018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) niversity Parkway Baltimore, MD 21218 20 Shannon Shevock MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 7 2004

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiens, 38609 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Daniels Teresa December 2004 2:22 A Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 151 South Meadow Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/4/1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 WV **Funeral** Days Months Hours 1 ☐ M 2) ☐ F Yrs. 88 Director 231-01-7150 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Anne Arundel Glen Burnie 1 ☐ Yes 2\\X\\No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 , or Items 23a 151 S. Meadow Drive USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo ģ Specify: Specify: 3X Widowed 4 □ Divorced natural White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Hairdresser or other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event SDR: 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Taddeo Carmela Servaperri ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Fleckenstein / daughter 151 S. Meadow Drive, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 12/07/2004 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Vancure MO1357 ark le 1 Second Ave, SW, Glen Burnie, MD 21061 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mensey ? **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disase r injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) o. detached 9 Unknown 9 Unknown á Division of Vital Records, P. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 2 1 ☐ Yes 2 ☑ No this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DEC 0 32. Registrar's Signature State 2004

Registrar

			1 - For Stata Ragistrar	State of Maryland		artment of He tificate of D			giene Reg. No.	004	38610
	Dhyoisi	22	1. Decedent's Name (First, Middle, Last	)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic			a Evans				Dec.	2	2004	10:20 AM
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or			4c. C	County of Death	
			Ester's Place 5. Social Security Number 6. Se		birthday)	If Under 1 Year	altimoı If Under 24 Hrs.		h	N A Birthr	A State or Foreign
	Funeral Director			M 2₽F 87	Yrs.	Months Days	Hours Min.	JUN 20,	y, Year)		place (State or Foreign ntry) 1 Carolina
7			Usual Residence of Decedent					DOIN 20,		/ SOUL	Larorina
2	how	_	10a. State 10b. County	10c. City, T	own or Lo	cation				1	Od. Inside City Limits
W	Be-f.s	Directo	Maryland N/A			Baltimon	re				1 X Yes 2 □ No
£	or 2	Dire	10e. Street and Number	<b>7</b> .		10f. Zip Code			10g. Citiz	en of What Coul	ntry?
400	s 23	eral	1634 Montpelier	12. Was Decedent Ever in U.S.	13 \		218	necity Yes or No	. 1.	USA 4. Race - Americ	an Indian
a to	ineri	Funeral	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No	10.1	Vas Decedent of His Yes, specify Cubar	, Mexican, Puert	o Rican, etc.)		Black, White,	etc.
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<b>S</b>	if Health and Menta itsm 27 is marked other traumatic ev	၉	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailin	g Address (Street a				Town, State, Zip	Code)
, Ma	m 27 is		Joyce V. Vaughan/N	liece	1634	Montpelie	r Street	t Reltin	ore	MD 2121	R
<b>.</b>	of Heal		20a. Method of Disposition	20b. Piac	e of Dispo etery, cren	sition (Name of natory or other place	)	Date	20c. Loc	ation - City or To	own, State
altimor	0 0		1 ☐ Burial 2 🂢 Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Tellioval from State	o Cre	matory, I	nc. 12/3	3/04	Bal	ltimore,	MD
<u>a</u>	Department Important: I any injury o		21. Signature of Funeral Service Ucense 22. Name and Address of Facility Cremation Society of MD. Inc.								
מ מ	105 a a			orchik	12	99 Freder	ick Road	L_Baltimo	ore,	MD 2122	8
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of								Approximate Interval Between Onset and Death
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or vita	this aldi	1-	1 ☐ Yes 2 No 27, Manner of Death		Outpatien  b. Time of	t 3 ☐ DOA Outle		ome 5 Resid			1.1
	E E	tlon	1 → Action 5 □ Pending investigation	(Month, Day Year)	Injury	Work	es 2 🗀 No	204. 20001.00 1	iow injury	00001100	Home
DIVISION	after death.  Director: After in by the fune	ifica	3 Suicide 6 Could not be	286. Place of injury - At nome	e, farm, str	eet, factory, office				Number or Rura	l Route Number,
i i	s after	Certification;	4  Homicide	building, etc. (Specify)				City or Tou	vn, State)		
000	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu			sician: To the best of my knowle							
1	tha F	<b>dedical</b>	one)	and manner stated.	. 2110/01/11						
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	N		Ingestes	- Cue of	3-1 (**		3 1 5	/	Je (	- 7,	2007
	0		30. Name and address of person who c Matthew McNabney				01+	. Im 01	001		
	Sta	te	31. Date filed (Month, Day, Year) DEC 0 7 2004	32/Registrar's Signatur	e 🔏	AF .	allimore	3, MD 21.	224		
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	1 - For State Registrar		aryland / Depa Cea	artment of H			eg. No. U	) 4	38611
Physician /Medical	DEWAW	OINE	ECK	45 Cit 7	A	Month 12.	03	Year 04	OZIO A M
Examiner  Funeral  Director	5. Social Security Number	BAYVIEW ME	1. CENTER ge (In yrs. last birthday) 70 Yrs.	BALTING If Under 1 Year Months Days	Location of Death  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
ס	215-30-6063  Usual Residence of Decedent  10a. State 10b. Count  MD Balt:		10c. City, Town or Lo			Oct 13,	1934	MD 1	0d. Inside City Limits
atter death with the Mar in Items 23a or 28a-f si inhet must be notified Finneral Director	10e. Street and Number 101 Center Place	ce Apt. 219		10f. Zip Code 2 1 2 2 2		1	og. Citizen of	State	es
5-UUSO 72 hours after death with the Maryland natural; or items 23a or 28a-1 show alsal Evaninat must be rigitified at	3 ☐ Widowed 4 ☑ Divorce	If Yes Give	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, fy: White	etc.
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Maryland 212 dd 2 should be filed with th and Mental Hygiene. 27 Is marked other than traumatic event, then	ຢູ່ 17. Father's Name (First, Middle <b>ກ</b>	Bacon		ng Address (Street a	18. Mother's Name	Smardo			Codel
timore, indi Pages 1 and 2 a timent of Health ar tant: If Item 27 is jury or other trau	Darlene Quiram  20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5 Other (  21. Signature of Funeral Service)	/Case Worker  3 □Removal from State Specify)	7401  20b. Place of Disponent of Chesapea	Holabird	Avenue, Doory 2	Baltimor Date ec 7		21222 - City or To	wn, State
	23a. Part 1. Enter the disease.	alil	d the death. Do not entine.	Cremation 8717 Green ter the mode of dyind	and Fune <u>Pasture</u>	s Drive	Balti	res _more,	MD Approximate Interval Between Onset and Death
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The The page	25. Was case referred to medic	al					ned? 2[ <b>X</b> No	prior to cor death?	psy findings available npletion of cause of 2 🔏 No
ding Physicis h. After this carl funeral direct	examiner?	Hospital: 1 Ninpati	ury 28b. Time of	f 28c. Injury Work	4   Nursing Ho	me 5 ☐ Reside 28d. Describe ho	ence 6 Ot		′)
Ital or ras after ral Direction Ital		mined 200. Place of In	jury - At home, farm, str tc. (Specify)			28f. Location (St. City or Town	o, State)		
To the Hosp within 24 hou To the Fune completely fil	(Check only 2 Medice one)  29b. Signature and title of certification	Exeminer: On the basis of and manner st	of examination and/or in	vestigation, in my op	pinion, death occurr	ed at the time, da	ate and place,  9d. Date signe	and due to	the cause(s)
State Registrar	e 31. Date filed (Many A. Day, Yea	n who completed cause of USCH John 32. Regist	,	Print) SAVVIEW Socre	4940 FASTI	enw AVE	Sun	mont,	MD 21224

State of Maryland / Department of Health and Mental Hygie 10 0 38612 - Stete Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2004 **Physician** 2, Gerald Rahn Ewald December 4:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Casey House Hospice Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 70 218-38-9369 24, 1934 Washington, D.C Director Oct. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Poolesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23g 15511 Sugarland Road 20837 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married XX Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Completed by 3 Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne any injury or other freumatic event, If item Additional pages. Elementary/Secondary (0-12) College (1-4or 5+) 2 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sterling David Ewald Florence Rahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Ann Ewald / Wife 15511 Sugarland Rd. Poolesville, MD 20837 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) December 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2004 Frederick, Maryland 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Perf . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medicai IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Subacute Bacterial Endocardial, Arterial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No or Attending Physicien: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence & Other (Specify) Hospice 1 🗌 Yes 2**X** No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 5 Pending investigation 1 XXNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel filled 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 041218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncasta Will Rd. Rockville AD Dr. Charles Harrison DEC 0 7 2004 32. Registrar's Signature State Registrar

		State of Maryland / Deparence		Reg. No. 2004 30613
Physic	ian	1. Decedent's Name (First, Middle, Last)  Mary I. Fuller	2. Date of De Month	Day Year,
/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	02 - 04 12:44 PM  4c. County of Death
Exami	ner	Franklin Square Hospital Center	Bosedale	Baltimore
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 4 50 74 9rs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Bir   Months Days Hours Min.   (Month, Days Aug. 8	9. Birthplace (State or Foreign Country)  1930 NewJersey
Pc ≥		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo		10d. Inside City Limits
Maryla f shov	ō		le River	1 ☐ Yes 2 XNo
ith the l	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
eath w	erai		Vas Decedent of Hispanic Origin? (Specify Yes or No	USA 14. Race - American Indian,
Ealtimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-1 show eny injury or other treumatic event, the Marked Examination and be notified at mones.	by Fun	1 Never Married 2 Never Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or Not Yes, specify Cuban, Mexican, Puerto Rican, etc.)  □ Yes 2 ★ Specify:	Black, White, etc.  Specify: White
21215-0036 d within 72 hours all giene. or then "neturel; or the Madical Exami		15 Decedent's Education 16a Decedent	dent's Usual Occupation	16b. Kind of Business/Industry
215 ithin 7 ie. "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	
d 21 filed w Hygier therti		12th Home	emaker  18. Mother's Name (First, Middle	OWN home  Maiden Sumame)
Maryland Maryland d 2 should be file lith and Mental Hy 27 is marked oth	To Be	Raymond A. Kelly	Ella Whilse	V
lary should be seen and he is male			ng Address (Street and Number or Rural Route Numb	
e, N 1 and 1 ealth 3m 27		Wesley Fuller / son 10.  20a. Method of Disposition 20b. Place of Dispo	4 Alcock Road Balting	ore MD 21221 20c. Location - City or Town, State
eC mor		1 Rurial 2 Cremation 3 Removal from State cemetery, crem	natory or other place) Crematory 12/6/64	Baltimore MD
Baltimore, permit. Pages 1 a Department of Hee Importent: if item importent: if item once.			Name and Address of Equilibration	yFuneralHomeofEssex
W SSES		R. Terry Connelly	300 Mace Ave Balt	imore MD 21221
		23a. Part 1. Enter the disease, or conditions that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	er the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
Pnysician /Medical		disease or condition resulting in death)  a. Lenton 15  Due to (or as a consequence of):		
Examiner		Techenia Bru	ne!	
led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter uncertainty Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  c. Practed 0	and with a of a late	11.
8760, rate be executed thysician and the burial-transit		that initiated events c.  Due to (or as a consequence of):	owel will perforated a	(01)
8760 cate be only sicia	dicai	d		
Box 68760, eath certificate be exattending physician for use as the burian	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	7	23d. Date of delivery
ecords, P.O. Box 687 law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	in the past 12 months?	Ectopic pregnancy   Other (specify)	Month Day Year
s that the med by a detace	by Ph	Part II. Other significent conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
ords equire		Severe Chronic Obstructive Pulmon		Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, for Attending Physicien: The law requires the flear death.  Director: After this certificate has been signed in by the funeral director, page 2 should be to the control of th	Completed	Chronic Prespiratory failure Chronic B	enal Insufficiency 24a. Was	24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec	e Col	Hypertension, Diabetes, Thyroiddiseas	Shock 1 Yes  26. Place of Death (Check only)	2 I No 1 Yes 2 No
f Vit ysicie is certi	To Be	examiner?  1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatier	Other	
In O		27. Manner of Death  1  Autural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury at 28d. Describe Work?	how injury occurred
isio	ficati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, str	M 1 ☐ Yes 2 ☐ No  eet, factory, office 28f, Location (	Street and Number or Rural Route Number,
Div	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or To	wn, State)
Division of Vital Re To the Hospitel or Attending Physicien: The Within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deatled the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Manjone Mile	RESOUDOD	12/02/04
1 7		Dr. Raniana Mitra 9000 Franklin Sq		1 21237
	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature  DEC 0 7 2004	and the same of th	
Regis	urar	2004 Director M		

James L. Fleming State of Maryland / Department of Health and Mental Hygiene UNK

04	-386		1 - State Registrar	•	Ce	rtificate of	Death	Reg.	2004	38614
			Decedent's Name (First, Middle, L.	ast)			2	2. Date of Death		3. Time of Death
	Physici /Medic		James L. Flemi	ngs			N	ovember	26, 2004	0800 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
			2925 Pulaski Hig	hway		Balti	more			
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8	Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign
	Director		219-66-5957	1 XM 2 ☐ F	48 Yrs.	Wionuis Days	1	1-10-5	6 MD	
	p .		Usual Residence of Decedent  10a. State 10b. County	10a Cit	y, Town or Lo	4:				
	aryia shov	-	,							10d. Inside City Limits Yes 2□No
	Ba-f	ctc	MD	Ba	ltimo					
	or 2	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	ath v 23a	rai	141 Ellwood Av			21231			JSA	
	er de Itami	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S.   13.	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
36	s aft	by F	1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		Specify: Bl	ack
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f show to Medical Exercise must be rediffed at	pa	15. Decedent's 8		16a Dece	ient's Usual Occup	ation	161	o. Kind of Business/l	ndustes
5	in 72 n "na	Completed	(Specify only highest g	rade completed)	(Give	kind of work done DO NOT use retire	during most of working	'	. Kind of Businessyl	idostry
12	filed with Hygiene other than	mo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Labo:	rer		W	arehouse	
	filed Hygin other ant,	Be C	17. Father's Name (First, Middle, Las	t)	,		18. Mother's Name (			
au	ould be i Mental I arkad o	ToB	William Flemin	a			Beatrice	Kellv		
Maryland	2 should land Menis marks	-	19a. Informant's Name/Relationship	*	19b. Mailir	ng Address (Street	and Number or Rural I		ity or Town, State, Z.	ip Code)
ž	0 0 0 0		Ernest Fleming	(brother)	1323	M Mon	tford Ave	Ralta	) MD	
ē,	s 1 a f Hea itam otha		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of natory or other place	Dat		. Location - City or T	own, State
E O	Pages nent of I int: If its iry or o		1 ☐ Surial 2 ☐ Cremation 3 i 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	. Carı		12-6-	.04	undalk M	D
Baltimore,	- 5 # · · ·		21. Signature of Funeral Service Lice	Trac	-	City and the city of the city	navis Jr.			D
ñ	permi Depar Impor any ir		Days log 1	but to			tern Ave.			1231
		_	23a. Part1. Enter the disease, or cor	nplications that caused the deat					J. PID Z	Approximate
	Pnysician		shock, or heart failure. List only immediate Cause (Final		· ·	73.00	1 1 0	1 E.	2. (	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aOue to (or as a conseq	JOU MA	(2) Ot K	ight arm	ound to	earm	
п	Examiner			Due to (01 as a conseq	derice or,					
		ē	Se ventially list conditions if any, leading to immediate	b. — Due to (or as a conseq	uence of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć,	exec in an	Exa	resulting in death) Last	Due to (or as a conseq	uence of):					
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cal		d.						
99	tificat ig phy as th	Medical								
Вох	h cer andin use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	incy	Terenia mananana			23d. Date of deliv	rery
Β.	that the death or ed by the attend detached for us	Physician	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	eath 5	Ectopic pregnancy Other (specify)			Month	Day Year
Ö	at the d by the tached	hys	9 🗆 Unknown	9Ll Unknown						
S,	ires that signed t I be det	by P	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
rd	w require been sig should t	ed						1 🗆 Yes	2 1 No 3 □ Pro	bably 4 Unknown
Records,	aw requas been 2 should	Completed						24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
æ	The lav te has	mo						autopsy performed 1 Yes 2	? death?	ompletion of cause of 2□ No
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>		To B	examiner? 1 <b>X</b> ] Yes 2 □ No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth			6 6 Other (Speci	(v) SCENE
J of			27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur Wor		d. Describe how in		,, DOLL IL
<u>o</u>	Attanding I ir death. actor: Atter by the tuner	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigate	Found 76-04	rung		Yes 2 □Xo	Suhl	ect sho	+
Division	Atta er de acto by th	ific	3 Suicide 6 Could not determined		ome, farm, str	eet, factory, office	28	Location (St 3et City or Town, St	and Number or Rug	al Route Number
D	s after al Dirac	Certification:	A	building, old. (Specif)	"Shee	+		12/L	1 +1 mare	Waski Hwy
	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: Atter the completely tilled in by the tuneral		29a. Certifier 1 Certifying P	hysician: To the best of my kno	wledge, death	occurred at the tir	ne, date and place, and	due to the cause	e(s) and manner as	stated.
	ha H in 24 ha F plete	edical	one)	miner: On the basis of examina and manner stated.	tion and/or in	restigation, in my o	pinion, death occurred	at the time, date	and place, and due t	o the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	( 00 0		29c. Licens	e number	29d.	Date signed (Month,	Day, Year)
}	18		Carde H	allaun	rd	0	.C.M.E.	Nov	vember 26,	2004
	15		30. Name and address of person who	completed cause of death (Item						
	·		CAROLHI	TLC HOUNG		1 Penn S	treet, Balt	imore, 1	Maryland 2	21201
	Sta	te ar	31. Date filed (Month, Day, Year)	2004 32. Registrar's Signa	ture	South)				

Registrar

			Registrar	State of Maryland / [ 23a per br., G8	epartment of Health and N 42 06/06/05/06 Certificate of Death	Reg.	
	Physic	ian	Decedent's Name (First, Middle, Last)	Coorne 5		Date of Death     Month	Day Year 3. Time of Death
>	/Medi Examir	cal	4a. Facility Name (If not institution, give st	George Freas	4b. City, Town, or Location of Death	Decemi	oer 3, 2004 12:48 a. M
				Morning Star Drive		ayton	Howard
	Funeral Director		579-26-9666	M $2\Box$ F 7. Age (In yrs. last bir	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Location	March 20, 1	926 Washington, DC  10d. Inside City Limits
	Marylan f show fed at	Ď	Maryland How		_		1 ☐ Yes 2 No
	r 28e	rec	10e. Street and Number	aiu	Dayton	10g.	Citizen of What Country?
	h with	a D	4984 Morning Star Drive		21036		,
320	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other then "neturel; or Items 23a or 28e-f show other treumatic event, the Marifiela Examinating reporting at	by Funeral Director	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Wes 2 □ No If 9 Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: NATH: 4-
รุ	2 hou	ted	15. Decedent's Educa	ition 16a.	Decedent's Usual Occupation	16b	White . Kind of Business/Industry
21215-0036	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	com <i>pleted)</i> College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing	NASA
N	filed with Hygiene. Ither ther	Con		4	Branch Head of Document	tation	IVASA
Maryiand	tal H d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid	len Sumame)
2	should be to marked or marked or umartic eve	J.	George W				Ostermayer
<u> </u>	d 2 sho th and 7 Is mu treum		19a. Informant's Name/Relationship (Type		Mailing Address (Street and Number or Rura		
บ๊	os 1 and of Health item 27		Mrs. Ruth Freas  20a. Method of Disposition	Wife 20b. Place of	4984 Morning Star Drive Da		d 21036 Location - City or Town, State
2	Pages nent of I int: If its		1 Burial 2 Cremation 3 Rei	noval from State cemeter	y, crematory or other place)	200	
baltimore,	- E E E		21. Signature of Funeral Service Dicensee	All Coun	ty Cremation Services, Inc. 12/0	06/2004	Sykesville, Maryland
ŏ	Department of the sany once.		Muldurkich	11 XD 10/17	Slack Funeral Home	РΔ	
			23a. Part1. Soter the disease, or complication of the state of the sta	ations that caused the death. Do n	ot enter the mode of dying, such as cardiac of	Pike Filicom Cit	y, MD 21043 Approximate
	nysician	J.,	Immediate Cause (Final disease or condition	CHRONICA	BSTRUCTIVE PULP	ADNARY O	Interval Between Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a consequence of		0147714	TOCHTSE LO TIENTE
	Examiner		Sequentially list conditions b.	<b>Berylliosis</b>			20 vears
	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	rf):		
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00/00	ficate be executed physician and s the burial-transit	a E		200 10 (01 20 2 001304201100 1	n).		
	ificate g phys	edical	d				
O. DOX	law requires that the death certific as been signed by the attending p. 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. If yes, outcome of pregnancy  1 Live birth 2 Petal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
L	res that igned by be deta		Part II. Other significant conditions contri	buting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
3	quires n sign	ed by	CARDID MYDPA	THY		1 ☐ Yes	2 □ No 3x Probably 4 □Unknown
vital necolus,	aw requir is been si 2 should	Completed	DIABETES ME	WITUS		24a. Was an	24b. Were autopsy findings available
	9 L 9	E O				autopsy performed? 1 ☐ Yes 2 🗷	prior to completion of cause of death?
	sicien: Tr certificate irector, pag	Bec	25. Was case referred to medical		26. Place of Death		No 1 ☐ Yes 2 € No
5	S S	To	examiner? 1 \( \text{Yes} \) 2 \( \text{Yo} \)	spital: 1 ☐ Inpatient 2 ☐ ER/Out	Other		6 ☐Other (Specify)
	aling h. After fune	ertification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		jury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred
5	i ji ji g	O	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		City or Town, Sta	
:	ne nospitei n 24 hours a he Funerel ( pletely filled	Medical	29a. Certifier (Check only one) Certifying Physic Medical Examine	<ul> <li>ian: To the best of my knowledge,</li> <li>On the basis of examination and and manner stated.</li> </ul>	death occurred at the time, date and place, a /or investigation, in my opinion, death occurre	and due to the cause( ad at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
i	To the Complet	Σ	29b. Signature and title of certifier	10011000100	29c. License number	_	ate signed (Month, Day, Year)
	3		* say "	raurer m	D29909	V	ECEMBER 3, 2004
	(0)		30. Name and address of person who comp		ype, Print)		,
	-61		Maurer, Scott MD 2465 Rt 31. Date filed (Month, Day, Year)	On Designation of the Control			<b>\</b>
	Sta Registr		DEC 0 7 000	32. Hegistrar's Signature			Y
МНС	H 17 Rev 1/20		DEC 0 7 2004	ploton &	good -		
				ORIG	INAL		

State of Maryland / Department of Health and Mental Hygie pen () [ 38616 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** 2125 P M Ossie Mae Fleming HOVEMBER 28 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Saint Agnes
5. Social Security Number Health Care Baltimore
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Months Hours Yrs. Director 153-18-8551 90 Aug 16, 1914 Florida Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event. The Medical Exercitival for notal ke notified at 1 ☐ Yes ≹☐ No Director Baltimore Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1513 Rawlingswell Road 21228 U.S.A. Completed by Funeral filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse 12 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental H int: If item 27 Is marked of Mary Henderson Ezekiel Jones 은 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Rawlingswell Road Catonsville, Maryland 21228 Ivin Towson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition UNE Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Department of Importent: If any injury or once. \*4 □ Donation 5 □ Other (Spegify) Florida Forest Lawn Cemetery 21. Signature of Funeral Service dens 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fabrire. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Urnary tract in Pechan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): 68760, Physician/Medicai Box ( IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Month Day 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Alzheimer's demenho Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No hballe hon 2 No Vital 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ot this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nmohammed P17601 MD NOVEMBER 28,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. Caton Avenue Baltmore, MD 2122 Nareesa NOHAMMED 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004 DHMH 17 Rev 1/2001

**ORIGINAL** 

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			State of Maryland / Department of Health and Me 1- State Certificate of Death	Reg. I	2004 38617		
	<b>S</b> 1 - 111			2. Date of Death	3. Time of Death		
	Physicia /Medic			oec E	2004 7 50 AM		
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  HAMPSTEAN		4c. County of Death  CARROLL		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	O Birthalaga (State or Foreign		
	Director			(Month, Day, Ye.	136 MARYLAND		
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		10d. Inside City Limits		
	Maryl	to	MO CARROLL HAMPSTEAD		1X Yes 2 No		
	th the or 28e	irec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?		
	ath wi	rai	3805 Sunnyfield Court APTIC 21074		USA		
	ter de Items iner	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ■ Never Married 2 ■ Married  1 ■ Yes 2 ▼ No	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
98	ours at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: White		
21215-0036	filed within 72 hours after death with the Maryland Hyglene. vither then "neturel", or Items 23a or 28e-1 ehow ent, the Medical Examiliat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	16b.	Kind of Business/Industry		
72	withir lene. then	dwo	Elementary/Secondary (0-12)  College (1-4or 5+)  O  NOT use refined)  NISA BLEO		NIA		
	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle, Maid	len Surname)		
ylaı	ould b Menta arked etic e	To		e East			
Maryland	d 2 sh th and 7 is rr treum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural  MARIAH SHIFMANKANEGIVER 7 Schilling Road Suite	210 HUNT			
	s 1 an f Heall item 2 other		20a. Method of Disposition 20b. Place of Disposition (Name of Da		Location - City or Town, State		
Ê	Page: nent o ant: If ary or		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  12 □ State  13 □ State  14 □ Donation 5 □ Other (Specify)	2004 54	Kesville, mb		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-1 ehow any injury or other treumetic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility JV				
	GD = 8 Q		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or		nsburg MN 21784  Approximate		
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of).				
	Examiner	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	mine	if any, leading to immediate cause. Enter United States and Cause (Disease or injury that initiated events c.				
o,	e exectian and anial-tra	Exa	resulting in death) Last  Due to (or as a consequence of):				
68760,	ficate be executed physician and s the burial-transit	edicai Examiner	d				
_	eath certifii attending p		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery		
. Box	law requires that the death certi as been signed by the attending 2 should be detached for use a	by Physician/M	in the past 12 months?  1		Month Day Year		
P.O.	at the d by th etache	Phys	9 Unknown	22a Did tahaaa			
	ires tha signed d be det		Part II. Other significant conditions contributing to death put not resulting in the underlying cause given in Part I.	1 Tes	o use contribute to the cause of death?  2  No 3 Probably 4 Unknown		
CO	w requir been si should	ete	100 0 000 000 000				
ဆ္	24a. Was an autopsy find prior to completion death?						
<u></u>	The law ate has t page 2 s	ompl	IN TOUR DAGGARTIE	autopsy performed			
/ital F	icien: The law ertificate has t ector, page 2 s	Be Completed	25. Was case referred to medical axaminer?	autopsy performed 1 Yes 2 (Check only one)	prior to completion of cause of death?  1 Yes 20 No		
of Vital F	Physicien: The law r this certificate has t ral director, page 2 s	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	autopsy performed' 1 Yes 2 (Check only one)	prior to completion of cause of death?  1 □ Yes 2 No  6 Dether (Specify)		
ion of Vital F	nding Physicien: The law ath. r: After this certificate has t e funeral director, page 2 s	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	autopsy performed 1 Yes 2 (Check only one)	prior to completion of cause of death?  1 □ Yes 2 No  6 Dether (Specify)		
ivision of Vital F	nr Attending Physicien: The law ter death. It death. Irector: After this certificate has the by the funeral director, page 2 s	To Be	25. Was case referred to medical examiner?  1   Yes   25   No	autopsy performed:  1 Yes 2  (Check only one)  1 Residence  2 Residence  2 Residence	prior to completion of cause of death?  To 1 Yes 22 No  6 Other (Specify)  jury occurred  and Number or Rural Route Number,		
Division of Vital Records,	pitel or Attending Physicien: The law burs after death. erel Director: After this certificate has t filled in by the funeral director, page 2 s	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No	autopsy performed:  1 Yes 2 (Check only one)  10 5 Residence  8d. Describe how in  8f. Location (Street City or Town, Str	prior to completion of cause of death?  To 1 Yes 2 No  6 Other (Specify)  jury occurred  and Number or Rural Route Number, ate)		
Division of Vital F	Hospitel or Attending Physicien: The 4 hours after death. Funerel Director: After this certificate h (ely filled in by the funeral director, page	Certification; To Be	25. Was case referred to medical examiner?    Yes   2	autopsy performed:  1 Yes 2  (Check only one)  1 Residence  2 Residence  2 Residence  3 Describe how in  3 Location (Street City or Town, Street)	prior to completion of cause of death?  No 1 Yes 2 No  6 Other (Specify)  jury occurred  and Number or Rural Route Number,  ate)  (s) and manner as stated.		
Division of Vital F	or Attending Physicien: The ufter death. Director: After this certificate h in by the funeral director, page	To Be	25. Was case referred to medical examiner?  1	autopsy performed:  1 Yes 2  (Check only one)  1 Sesidence  8d. Describe how in  8f. Location (Street City or Town, Stand due to the cause d at the time, date a	prior to completion of cause of death?  No 1 Yes 2 No  6 Other (Specify)  jury occurred  and Number or Rural Route Number,  ate)  (s) and manner as stated.		
Division of Vital F	Hospitel or Attending Physicien: The 4 hours after death. Funerel Director: After this certificate h (ely filled in by the funeral director, page	edical Certification; To Be	25. Was case referred to medical examiner?  1	autopsy performed:  1 Yes 2  (Check only one)  1 Sesidence  8d. Describe how in  8f. Location (Street City or Town, Stand due to the cause d at the time, date a	prior to completion of cause of death?  1 Yes 2 No  6 Sther (Specify)  ijury occurred  and Number or Rural Route Number, ate)  (s) and manner as stated.  and place, and due to the cause(s)		
Division of Vital F	Hospitel or Attending Physicien: The 4 hours after death. Funerel Director: After this certificate h (ely filled in by the funeral director, page	edical Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom  27. Manner of Death 1 Natural investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determited 28e. Place of Injury - At home, farm, street, factory, office 29e. Certifier (Check only one) 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and major stated.	autopsy performed:  1 Yes 2  (Check only one)  1 Sesidence  8d. Describe how in  8f. Location (Street City or Town, Stand due to the cause d at the time, date a	prior to completion of cause of death?  1 Yes 2 No  6 Sther (Specify)  ijury occurred  and Number or Rural Route Number, ate)  (s) and manner as stated.  and place, and due to the cause(s)		
Division of Vital F	Hospitel or Attending Physicien: The 4 hours after death. Funerel Director: After this certificate h (ely filled in by the funeral director, page	Medical Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier 29c. License number 29c. License number 29d. Name and address of person who completed cause of death (Item 23a) (Type) Print)	autopsy performed:  1 Yes 2  (Check only one)  1 Sesidence  8d. Describe how in  8f. Location (Street City or Town, Stand due to the cause d at the time, date a	prior to completion of cause of death?  1 Yes 2 No  6 Sther (Specify)  ijury occurred  and Number or Rural Route Number, ate)  (s) and manner as stated.  and place, and due to the cause(s)		

State of Maryland / Department of Health and Mental Hyd

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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland

Division of Vital Records, P.O. Box 68760,

ian	<ol> <li>Decedent's Name (First, Middle</li> </ol>	a fact)					2. Date of De	Reg. No.		3. Time of Dea
ical	Darryll Be		sher				Month NOVEME	Day	_	
ner	4a. Facility Name (If not institution 755 McCABE AVEN		nber)			TIMORE C	h		County of Death	
Г	5. Social Security Number 212-86-6208	6. Sex 1√2 M 2□ F	7. Age (In yrs. I	ast birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th iy, Year) ,196	Cou	place (State or Fo. Intry) / Land
١	Usual Residence of Decedent  10a. State 10b. County  Maryland N	/ A		/, Town or L						10d. Inside City Li
Directo	10e. Street and Number 724 McCabe Av			Balti	10f. Zin Code	212		10g. Citizen of What Country?		
To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dece Armed Fo	2 ( <b>½</b> (No re		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 1	4. Race - Ameri Black, White	
Completed t	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education		(Give	dent's Usual Occup a kind of work done DO NOT use retire ck Cler	during most of wo d)	rking		nd of Business/Ir S Club	ndustry
To Be Co	11th grade 17. Father's Name (First, Middle, Joshua Butle	r, Jr.					me <i>(First, Middle)</i> ea Fish		Surname)	
	19a. Informant's Name/Relations Debra Minter		wife	19b. Maili 724	ng Address (Street McCabe 2	and Number or Ru Avenue	ural Route Numb Baltimo	er, City or ore , l	Town, State, Zi Marylai	nd 2121
	20a. Method of Disposition  x		C CE	emetery, cre	osition (Name of matory or other plan Memoria		/ <sup>9</sup> 4/04	20c. Loc Arbi	ation - City or T utus,	own, State Marylar
	21. Signature of Funeral Service	Licensee			2. Name and Address 240 Rei:	· .	hatman- wn Rd E	-Har: Balt	ris Fui imore,	neral H Md 2121
	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								Interval Betwee Onset and Dea	
Ical Examiner	that initiated events	Due to (								
Medical	that initiated events	c	or as a consequicome of pregnal ifth 2 Fetal ant at time of de	ncy death 3[	□Ectopic pregnancy	,		2	3d. Date of deliv	•
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	c	or as a consequicome of pregnal inthemolecular time of delivers.	ncy death 3[ ath 5[	Other (specify)		23e. Did t	obacco us	Month se contribute to t	Day Year
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Completed by Physician/Medical	Lause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	c	or as a consequence of pregnation of the comment o	ncy death 3 [ sath 5 [	Other (specify)	en in Part I.  26. Place of Dea	24a. Was	obacco us Yes 2 an osy zemed? 2 \square No	Month se contribute to t No 3 Proi 24b. Were aut prior to co death? 1 Deas	Day Yea the cause of deat bably 4 □Unki ppsy findings ava pmpletion of caus 2 □ No
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n: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes 2   No 27. Manner of Death 1   Natural 5   Pendin	Due to (  c. Due to (  d. 23c. If yes, out 1   Live b 4   Pregn 9   Unknown ons contributing to do (  Hospital: 1   1   1   28a. Date (  (Mont) on to be 28e. Place 28e. Place	come of pregnal irth 2 Fetal ant at time of decomposition of the composition of the compo	Dence of):  ncy death 3[ ath 5[ withing in the continuous state of the continu	Other (specify)	en in Part I.  26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ □	24a. Was autop period period to the same some some some some some some some so	an obacco us yes 2) an obsy rmed? 2 \square No one) dence 6 now injury	Month se contribute to t No 3 Prol 24b. Were autr prior to co death? 1 Des	Day Year the cause of death bably 4 □Unkr oppy findings avai ompletion of cause 2□ No  SCENE
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al Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (d	come of pregnal irth 2 Fetal ant at time of depwn eath but not result of Injury h, Day Year)  7 7 6 Injury - At hong, etc. (Specify Consists of examinat	ncy death 3 [ ath 5 ] ath 5 [	other (specify)  Inderlying cause give  and 3 DOA other  28c. Injur Wor  AM 1  reet, factory, office	en in Part I.  26. Place of Dea er: 4 □ Nursing F y at k? Yes 2 □ 1.  me, date and place pinion, death occu	24a. Was autop performent of the control of the con	an syrmed? 22 No one) dence 5 now injury. State) Mill (Size and July 29d. Date	Month  se contribute to to the second of the	the cause of death bably 4 Unkr opsy findings avai ompletion of cause 2 No  Ty) SCENE  A Four Number  A Four Number  of the cause(s)  Day, Year)

		•	For State Registrar		State of Ma	aryland /	Department <i>Certificate</i>				giene 0 0	4	38619
			Decedent's Name (Fire	st, Middle, Last,	)					2. Date of Dea	ath	V	3. Time of Death
	Physicia /Medic		Meric	Eliza	beth	Franc	15			Month ☐ e c	03 2	VO4	5:30 A M
	Examin		4a. Facility Name (If not		street and number)		4b. City, 7		cation of Death		4c. County	1 .	
	_			LUNCING					More Under 24 Hrs.	8. Date of Birt	· v		ace (State or Foreign
	Funeral Director		5. Social Security Number 314-30-08	43 10	M 20 F 7. A9	e (In yrs. last b			lours Min.	(Month, Day	Year) 934	WAS	HDC
	and	-	Usual Residence of Deci 10a. State 10b	. County	/.	10c. City, Tov	vn or Location					10	d. Inside City Limits
	after deeth with the Marylar or Itams 23a or 28a-f show mitter a ust be notified at	tor	MD	14/	4		BACTIN	ORE					1 Yes 2 □ No
	th the	Funeral Director	10e. Street and Number				10f. Zip				10g. Citizen of \	What Count	try?
	ath wi	raic	2018 A.	SHLAN		ENUE		2/2				SA	
	er de Itams	nue	<ul><li>11. Marital Status</li><li>1 □ Never Married</li></ul>	25 Marriad	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		13. Was Deced	ent of Hispa	anic Origin? (Spe √féxican, Puerto	ecity Yes or No- Rican, etc.)	Blac	ce - America ck, White, e	
36	within 72 hours after deeth with the Maryland ane. than "natural", or Itams 23a or 28a-f show to Moulgal Examinating the notified a	by F	3 Widowed 4		If Yes, Give Year or Dates:	140	1 □ Yes 2	No S	Specify:		Specify	" B	LACK
5-0036	natural',	Completed	15. (Specify of	Decedent's Edu	ication le completed)	168	a. Decedent's Usua (Give kind of wor	l Occupation	n na most of worki	ng	16b. Kind of B	usiness/Ind	lustry
2	be filad within 72 hatal Hygiene. Id other then "natuevent, Its Madical	mple	Elementary/Secondary	-	College (1-4or	5+)	life. DO NOT us	e retired)	S Any	20	M	100	TOM
22	filad with Hygiene. other ther	e Co	17. Father's Name (First	, Middle, Last)	/ YEA		NUR	-	. Mother's Name	(First, Middle,	Maiden Suman	ne)	
Maryland	should be filad within the Mental Hygiene. marked other than matic event, ILE M	To Be	GEORG	E I	D. PAK	RAN			MA	RIE	HA	IRRI	10
ary	should and Menias marka	-	19a. Informant's Name/		vpe, Print)	19	b. Mailing Address	(Street and	Number or Rura	I Route Numbe	er, City or Town,	State, Zip	Code)
	and 2 ealth a n 27 Is		PETER M	. FRA	NC75/H	USBANZ	2018	ASH	MAND.	AVE,	SALTO,	MI	2/205
ore	of He of He it itam	1	20a. Method of Dispositi		Removal from State	comet	of Disposition (Namery, crematory or of	ne of ther place)		Date	20c. Location -	· City or Tov	wn, State
Baltimore,	Pages thent of tant: If it it		° 4 □ Donation 5 □	Other (Specify)		CEPA	R HTLL			2-8-04	EROP	lyn, 1	AACO, MID
Bal	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marka any injury or othar traumatic once.		21. Signature of 5	Service Licens	. X	10.	22. Nam e and	d Address o	of Facility	110100	Tim	ERM	MD 25007
			23a. Part 1 Enter the di	Sease, or comp	lications that cause ine cause on each li	d the death. Do	not enter the mode	e of dying, s	such as cardiac o	or respiratory ar	rest,	HUO,	Approximate
	Constator		Immediate Cause (Fina		4 1								Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)	-	a /+cv/e Due to (or as	a consequence		INTa	inchion				30'
	Examiner		Sequentially list condition	ons	b. =								
	sit ad	Iner	if any, leading to immed cause. Enter Underlying Cause (Disease or injury	liate <b>II</b>	Due to (or as	a consequence	of):						
	and and I-trans	Examiner	that initiated events resulting in death) Last		c	a consequence	e of):						
38760,	eath certificate ba exacuted attending physicien and for usa as the burial-transit				, ,		,						
687	ificate g phys	edical			d								
Вох	h cert ending	M/UR	IF FEMALE: 23b. Was decedent pre-	gnant	23c. If yes, outcome	of pregnancy 2 Petal deal	th 3□Ectopic pro	egnancy				ite of delive	•
	as that the death cert igned by the attendin be detached for usa	Physiclan/M	in the past 12 mon 1 Yes 2 No		4□Pregnant a 9□Unknown		5 Other (spe				Mic	onth	Day Year
P.O.	nat the d by t letach		9 Unknown Part II, Other significan	t conditions or	entributing to death h	out not resulting	in the underlying o	ause civen i	n Part I	23e. Did to	obacco use cont	tribute to th	e cause of death?
ds,	iaw requiras that the death certif as been signed by the attending 2 should be detached for usa a	d by	, and the state of		, in our ground	, , , , , , , , , , , , , , , , , , ,		acco given		10			ably 4 □Unknown
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Re	9 4 9	ошо								autor perfo	rmed?	prior to con death? 1  Yes	npletion of cause of
Vital		a	25. Was case referred t	o medical				26	6. Place of Death				
<u></u>	Physiclan: r this certific rral director,	To B	examiner? 1 ☐ Yes 2 No		Hospital: 1 🔲 Inpati	ent 2 ERVO			Nursing Ho	me 5 Resid	dence 6 Oth	ter (Specify	)
n of	ing Pl		27. Manner of Death 1 Natural 5	☐ Pending	28a. Date of Inju (Month, Da	ay Year) 28b.		8c. Injury at Work?		28d. Describe I	now injury occur	red	
isio	ttand death stor: / the f	icat	2 ☐ Accident 3 ☐ Suicide 6	investigation  Could not be	28e Place of In	iury - At home	farm, street, factory		s 2 □ No	28f. Location (S	Street and Numb	ber or Rura	I Route Number.
Division	after Dirac	Certification;	4  Homicide	determined		tc. (Specify)	iaini, otroot, ractory	, 0.1100		City or Tov			
	To the Hospital or Attanding Phye within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	edical C			/sician: To the best	of examination a							
	o the ithin 2 o tha omple	Med	29b. Signature and title	of certifier	and manner s	-	290	. License no	umber		29d. Date signe	id (Month, I	Day, Year)
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	h		30. Name and address	of person who c			) (Type, Print)	,	20 100				21201
	.)		Daniel	R.	1 tow		821	N. E.	ctw '	405	BUK,	nove.	M
	Sta Regist	ate rar	31. Date filed (Month, D		32. Regist	rar's Signature	(Type, Print) 821	park.	2				

Amend item#19a, perff, G338, 12/7/04 11 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38620 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:45 AM Elaine Feldstein December 3,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Northwest Hospital Center Raudalls town If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🛣 F Months **Director** 212-30-1582 09/25/1932 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, It at Maryland Exercities Invest be inclined at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTT LEVEL ROAD 21208 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∏Yes 2 🕅 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) COHEN ALBERT TOBA 2 RIBERKOW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACEY PALIATH / NEICE NIECE 2217 SUGARCONE ROAD BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State To = 20 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. SHAAREI TFILOH CONG. 12/05/2004 WOODLAWN, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Total 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Aspiration preumoning /Medical Due to (or as a consequence of **Examiner** cerculorascular accident Sequentially list conditions, I any, loading to initional acases. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Que to for as a nonsecuenne offi burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Vnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 X Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural s after decral Diractor: Att 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L tilled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Pages .

the Hospital or Attanding Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

Randalistonn

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Old COUNT ROCK

31. Date filed (Month, Day, Year) 7 2004

29c. License number

Mandand

outh

Manyjay Mejia

00060567

21133

29d. Date signed (Month, Day, Year)

December 3, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier® 0.0 L

	1- For Amend Item 27 Registrar	per Dr., 6838, I	2/07/04dhb Certificate	of Death	rivieritai riyyi Re	ig. No.	38621
Physicia	1. Decedent's Name (First, Middle 1.	ist)	- (1		2. Date of Death		3. Time of Death
/Medica	al Rosiyn P		edd		Novemb	er 26, 20	03:54A
Examine	Union Memo	1 1 1		own, or Location of De Utimore		4c. County of De	eath
Funeral Director	5. Social Security Number 6.	Sex 7. Age (In yrs. las	t birthday) If Under 1	Year If Under 24 H Days Hours Mi	n. 8. Date of Birth		irthplace (State or Foreign Country)
3	Usual Residence of Decedent				DUIY 19	, 1956	TALD
h tha Maryland r 28a-f show	10a. State 10b. County		Town or Location				10d. Inside City Limits 1 XYes 2 □ No
tha Ma 28a-f	10e. Street and Number	132	1timore		10	og. Citizen of What (	
th with 23e or	3204 Ramoi	na Avenue		213		1.15 C	L
6 atter death with or items 23e or	10e. Street and Number  320 4 Ramol  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?		nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No-		nerican Indian,
036 urs a	3 ☐ Widowed 4 Divorced	1 □Yes 2 No If Yes, Give Year or Dates:	1 🗆 Yes 2	•	Thousan, oto.)	Specify: T	Black
15-003	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Usual (Give kind of work	done during most of w	orking 1	6b. Kind of Busines	
2121 d within giene. or then	(Specify only highest gr (Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	admin.	Assist	ant F	3 to A	1ed. Center
land 2	17. Father's Name (First, Middle, Las.	)	· ((1))	/	ame (First, Middle, M		rea. Canq
iore, Maryland 212. ges 1 and 2 should be filed within 1 of Health and Mental Hygiene. If item 27 is marked other then or other traumatic event, the M	P Kobert L. 1	Mc Intosh			frice m		
Maryl d 2 shoul th and Me it is marl traumati	19a. Informant's Name/Relationship		19b. Mailing Address (S			100000	
other tr	15eotrice Tyle 20a. Method of Disposition	20b. Plac	e of Disposition (Name	of	Date 2	Oc. Location - City of	D 21213 or Town, State
Baltimore bernit. Pages 1: bepartment of He mportant: If itan iny njury or oth	1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci	Removal from State Dro	sid Ridae	erpiace)			
Baltim permit Pag Deportment Important: any njury c	21. Signature of Funeral Service Lice	1500	22. Name ad	Address of Facility	mes A. A	1orton &	ore MD Sons F. H., In
	James G	. forton	1701	aurens	Sti Bo	ultimore	MD 21217
222	23a. Pard. Enter the disease, or comshock, or heart failure. List only	one cause on each line.					Approximate Interval Between Onset and Death
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ecuta and -trans	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Nypert  Due to (or as a consequent	ension				204CUV3
			pidemia				likar
687 tificate og physi as the b	IF FEMALE:	d	71110				
Box		23c. If yes, outcome of pregnancy		nancv		23d. Date of de	•
Is, P.O. BOX	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  2  Inknown	4□Pregnant at time of deat 9□Unknown				Month	Day Year
that the sad by detac	Part II. Other significant conditions	ontributing to death but not resulting	ng in the underlying caus	se given in Part I.	23e. Did toba	acco usa contribute	to the cause of death?
of Vital Records, Physicien: The law requires to this certificate has been signed and director, page 2 should be on the formal the f	0 0 10 00 1	whacea abus					robably 4 Unknown
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I Rec	E 0				autopsy performe	prior to death? XNo 1 ☐ Ye	completion of cause of s 2 🗽 No
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iding th.: Atter	O 1XXNatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury M	Injury at Work?	28d. Describe how	vinjury occurred	
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Diffel or install of i					1		
Division of Vital Re To the Hospital or Attending Physicien: The Within 24 hours after death.  To the Funarel Director: Atter this certificate ha completely filled in by the funeral director, page	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example one)	ysicien: To the best of my knowle niner: On the basis of examination and manner stated.	dge, death occurred at t and/or investigation, in	he time, date and place my opinion, death occ	e, and due to the cau surred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
To the within To the comple	29b. Signature and title of certifier	1	29c. L	icense number	290	d. Date signed (Mon	th, Day, Year)
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12-11	30. Name and address of person who			050736 Street	R.11.	do O	1.2
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	la Medical	STELL	Dalhwo	L MID	21201
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			For State	State of Maryland	/ Department of H		ental Hygien	211111	38622
			Registrar  1. Decedent's Name (First, Middle, Last	)	- Cortinoato or		2. Date of Death	10.	3. Time of Death
	Physici		ROBERT	MALLOYD	GRANTS	R.	December D	ay Year	6:33 PM
}	/Medic Examin		4a. Facility Name (If not institution, give			r Location of Death		c. County of Death	
		*	St. Agnes Health	iare	Baitim			/i	)/A
	Funeral Director		227-72 0 DD '	7. Age (In yrs. las	st birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea MARCH 25	9. Birth 1937 V	place (State or Foreign ntry) CGINIA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location		/		10d. Inside City Limits
	e Maryk Be-f sho	Director	MARYLAND N	/A	BAL	TIMOR	E CIT	7	1ÆYes 2□No
	with th		10e. Street and Number	12 01 - 1 0.	10f. Zip Code	9,00	10g. C	iyzen of What Cou	
	eath 's 234	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of h	Hispanic Origin? (Spe	cify Yes or No-	USF 14. Race - Ameri	
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28e-f show event, the Madical Evarther I. and be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	. 13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto F Specify:	Rican, etc.)	Black, White,	etc.
9	tural	edt	15. Decedent's Edu	cation	16a. Decedent's Usual Occup	pation	16b.	Kind of Business/In	idustry
21215-0036	within 72 nne. Ihan "na e Madii	Completed	(Specify only highest grad	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d) -	25-4	0	+1D
			17. Father's Name (First, Middle, Last)		SECUR		(First, Middle, Maide		140
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ary	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailing Address (Street	and Number or Rura	Route Number, City	or Town, State, Zij	Code)
_	127 E		ALICIA DARDE	V (DAUGHTER)			3H CIRCLE		MD.21244
Baltimore,	90 = 2		20a. Method of Disposition 1.△ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ce of Disposition (Name of metery, crematory or other pla	ce)		L cation - City or T	
ij	그두명금	100	' 4 □ Donation 5 □ Other (Specify)		BUTUS (EME	and the second s	4-04 AK	BUTUS	MARYLAND
Bal	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	N. Willia	22. Name and Addre	J. FULTE	DA AVE.	BALTO,	MD. 21217
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	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	J			
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Box	death e atter id for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal d		y		Month	Day Year
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Records, I	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions co	ntributing to death but not result	ting in the underlying cause giv	en in Part I.		o use contribute to t 2 No 3 □ Prot	
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no	ding P. h. After funera	tlon	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo	rk? Yes 2 □ No	8d. Describe how inj	ury occurred	
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Ö	tal or	Certification:	4 Homicide	building, etc. (Specify)		4	City or Town, Sta		
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	ledge, death occurred at the ti on and/or investigation, in my o	me, date and place, a opinion, death occurre	and due to the cause( ad at the time, date a	s) and manner as s nd place, and due t	stated, to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	MANTANA A	A M An 29c. Licens			ate signed (Month,	
	N		YATUAR	V 1100 INVITE	11 (04 )	17495	Dec	ember 1	, 2004
\	3		30. Name and address of person who co Sanjay Vinjamar		23a) (Type, Print) Caton Avenue R	pathmore,	UD 2122	9	
	Sta Registi		31. Date filed (More Cay 0 0 200	32. Rogistrar's Signatu	& Son s	:			

GRANT, ROBER!

	-1		1 - State of N		artment of Health and I	Mental Hygien Reg. N	004 00060
	Physicia		1. Decedent's Name (First, Middle, Last)	6	Wenc-BEY	2. Date of Death Month D	ay Year 3. Time of Death
	/Medic Examin		4a. Facility Name (I) not institution, give street and number	2:12/	4b. City, Town, or Location of Death		c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. A	Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign
	Director	-	578-68-4409 X M 2 F Usual Residence of Decedent	52 Yrs.	Months Days Hours Min.	Oct. 24, 1	952 Maryland
	yland how		10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits
	he Mai	ector	Md. PG	Ft. Wash			1X Yes 2 □ No
	3e or 3	i Dir	10e. Street and Number 6510 Buckland Court		10f. Zip Code 20744		itizen of What Country? USA
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: If Item 27 ie marked other then "naturel", or Items 23e or 28e-1 show amy njury or other traumatic event, the Medical Eracia at Innatice Inclified at once.	by Funeral Director	11. Marital Status  12. Was Deceder Amed Forces  ↑ Never Married 2 ☐ Married  1 ☐ Yes, Give	5? • No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☐ ★lo Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Ö	thours	ed p	15. Decedent's Education	16a. Dece	edent's Usual Occupation	16b.	Kind of Business/Industry
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d 21	Hygier ther th	Cor	12th  17. Father's Name (First, Middle, Last)	Hand	dy-Man	ne (First, Middle, Maide	f Employed
<u>Ilan</u>	uld be Jental rrked o	To Be	Jessie Mason Givens			ina Prest	·
Maryland 21215-0036	12 sho h and h 7 ie ma		19a. Informant's Name/Relationship (Type, Print) Sis Bernadette Givens Jorr	ster 6510	ing Address (Street and Number or Ru  Buckland Ct		or Town, State, Zip Code) ington, Md. 20744
re,	s 1 and f Healt item 2	-	20a. Method of Disposition	20b. Place of Disp			ocation - City or Town, State
Baltimore,	Page ment o ent: if ury or		1 ☐ Burial 2 XCremation 3 ☐ Removal from Stat `4 ☐ Donation 5 ☐ Other (Specify)	Riverda	ale Crem.   12/		erdale, Md.
Ball	Deport Import any nj		21. Signature of Funeral Service Licensee	*	$^{22. ext{Name}}$ and Address of Facility $ ext{Tr}$		
			23a. Part 1. Seter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do not en			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CiA			Onset and Death
Į.	Examiner		4001	is a consequence of):	Iniury		15 deus
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of):	3 1		
oʻ	an and rial-tra	Exar	that initiated events	s a consequence of):			
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical	d				
Box 6	eath certifii attending p I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome				23d. Date of delivery
o.	that the death ed by the atte detached for	Physician/Me			□Ectopic pregnancy □ Other (specify)		Month Day Year
ords, P.	The law requires that the size has been signed by the bage 2 should be detache	ed by P	Part II. Other significant conditions contributing to death	but not resulting in the t	underlying cause given in Part I.		use contribute to the cause of death? ! Mo 3 ©Probably 4 □Unknown
l Records,	The law rate has be page 2 shu	Completed by				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No.	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other	th (Check only one)	
Division of Vital	tending Physicien: The leath. tor: After this certificate hathe funeral director, page	tion: To	27. Manner of Death  1 Natural 2 Accident  1 Sending 2 Accident  1 Sending 2 Accident  1 Sending 2 Month, C	jury 28b. Time o	IN 3 DOA 4 Nursing H	ome 5 ☐ Residence 28d. Describe how inju	
Divisi	of or Attend after death Director: A d in by the f	Certification;	3 Suicide 6 Could not be 28e. Place of le	njury - At home, farm, si etc. <i>(Specify)</i>	reet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one) 15 Certifying Physician: To the besi and manner and manner of the property of the control of the property of the prop	of examination and/or in	th occurred at the time, date and place exestigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
	To the within 24	Me	29b. Signature and title of certifier		29c. License number	29d. Da	ate signed (Month, Day, Year)
	Λ,		Medical Medical	Doctar	KES-000	Nov	EMber 26, 2004
	3		30. Name and address of person who completed cause of Allison Habas 600 N. Wo	IFE STREET	Bathmore, MA	Expland 21:	287
	Sta Registr	te		trar's Signature	boats	7	

			State of Maryland / Department of Health and Mental Hy  1 - For State Registrar Certificate of Death	giene 004 38624		
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  2. Date of De Month Nov. 2	Day Yeer 3. Time of Death 29, 2004 5:00 P. M		
	Examir Funeral Director		Eastpoint Rehab. & Nursing Center Essex  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birthday Months Days Hours Min. (Month, Days Hours Min. (Month, Days Hours Min.)	Baltimore  Baltimore  A Bithplace (State or Foreign		
	D		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits  ★☆Yes 2□No		
	with the Part or 28a-	Direct	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?		
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Midical Examiner must be multiled at ODGE.	by Funeral Director	2116 Braddish Avenue 21216  11. Marital Status 1	USA  14. Race - American Indian, Black, White, etc.  Specify: Black		
21215-0036	id within 72 ho giene. er than "naturi i the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 6th grade  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Nurses Assistant	16b. Kind of Business/Industry Fort Howard V.A. Hospital		
Maryland	uld be file Mental Hy irked oth	To Be (	of 17. Father's Name (First, Middle, Last)  Olden Griffin  Rosie Di	iamond		
Mar	und 2 sho alth and 1 27 is me er traume		19a. Informant's Name/Relationship (Type, Print)  Anthony Griffin/ Son  19b. Mailing Address (Street and Number or Rural Route Number)  2116 Braddish Avenue Balt			
altimore,	Pages 1 a ment of Hea ant: If item ury or othe		20a. Method of Disposition  1 Surial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other place)  Carrison Forest Vet. Cam.	20c. Location - City or Town, State  Wings Mills, Md		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Ucensee  22. Name and Address of Facility Chatman— 5240 Reisterstown Rd B	Harris Funeral Home altimore,Md 21215		
	Physician /Medical		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart ailure. List only one cause on each line.  Impediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Interval Between		
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Cause (Disease or injury)	EPDE		
8760,	cate be executed obysician and the burial-transit	Ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  DIABETES SYELLI TOS  Due to (or as a consequence of):  DEMENTIA			
P.O. Box 68	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery  Month Day Year		
	w requires that been signed by should be deta	Ď	þ	Part II. Other significant contains contributing to death but not resulting in the underlying cause given in Part I.	tobacco use contribute to the cause of deeth?  Yes 2 \( \subseteq \text{No} \) 3 \( \supseteq \text{Probably} \) 4 \( \subseteq \text{Onknown} \)	
Vital Records,	i <b>ician</b> : The law requ certificate has been rector, page 2 shoul	Completed				
Division of Vita	ding Phys n. After this funeral di	atlon: To Be	examiner?  1 Yes 2 700 Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Resident	one)  dence 6 □Other (Specify)  how injury occurred		
Divis	ial or Attendest s after death al Director: ed in by the	Certification:	3 Suicide 4 Homicide  3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 Homicide  4 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Street and Number or Rural Route Number, wn, State)		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	date and place, and due to the cause(s)		
1	on T with	2	Sovialor 4 Tipe ap D27188	29d. Date signed (Month, Day, Year)		
1	2 (1		30. Name and address of person who completed cause death (Item 23a) (Type, Print)  Saviable N Sylle 2 Have Place Dunk	Dec MU 21222		
	Sta Registr		31. Date filed (Month, Day, Year)			

			1 - For State Registrar	State of Maryland		artment of F		nd Mer		ene . N2 () (	) L	38625
	Physicia		1. Decedent's Name (First, Middle, Lass	HAMILLT	òN.				Date of Death Month	Day	Year	3. Time of Death 9:45 &
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of	f Death	-	4c. County		
	Examili	eı	Lorien Nursir			Balti				n	′a	
	Funeral Director		5. Social Security Number 216-14-4175 6. Se		ast birthday) Yrs.	If Under 1 Year Months Days		Min	Date of Birth (Month, Day, Y ay14,1	923	Cou	place (State or Foreign ntry) Yland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	r, Town or Lo	cation						10d. Inside City Limits
	Mary	to	MD Balti	.more	Wh	ite MAr	sh					1 ☐ Yes 2 🔯 No
	th the	irec	10e. Street and Number			10f. Zip Code			10g	. Citizen of V	hat Cou	ntry?
	ath wi	ral	5929 Loreley E				162			USA		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiens, and Mental Hygiens, is marked other than "natural; or tiems 23a or 28a-f show aumatic event, the Medical Evanthar must be redified at	by Funeral Director	11. Marital Status  1 □ Never Married <b>24</b> □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2€ No	lispanic Orig an, Mexican, Specify:	in? (Specify , Puerto Rica	Yes or No- in, etc.)	Blac	- Ameri k, White, Whi	
8	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation		16	b. Kind of Bu		
Maryland 21215-0036	d within 7 giene." er than "n i the Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired SPETSON	d)	or working		retai	1	
nd	d be filed vintal Hygie ad other to event, III	Be	17. Father's Name (First, Middle, Last)						rst, Middle, Ma		e)	
<u>Ş</u>	should and Men marka umatic	ပ	Thomas Moses H		10b Mailie	ng Address (Street			Reglar		State 70	a Codo)
<u>ā</u>		1	Ernest Hamilto			9 Lorel				•	-	
o e	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	esition (Name of matory or other place	rel	Date		c. Location -		
altimore,	Pages nent of t ant: If its ury or o		1 🔀 Burial 2 ☐ Cremation 3 ☐ 1 1 4 ☐ Donation 5 ☐ Other (Specify	nemovariioni State		nForest		12/9/	04 Ov	vings	Mil	ls MD
Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	Connell	14 22	2. Name and Addre		Con	nellyF	unera	1Ho	meofEssex
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the death	per not ent	er the mode of dyin	ng, such as c	cardiac or re	spiratory arres	,		Approximate Interval Between
	Physician	Ì	Immediate Cause (Final disease or condition	a ADVANCE	DI	)EMENT	IA					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ								
		ē	Sequentially list conditions,	b. Due to (or as a consequ	ience of							
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
o,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):							
8760,	ate be	dical		d		<del></del>						
Box 6	death certificate be executed the attending physician and ad for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent premant in the past 12 menths? 1 □ Yes 2 ☑ No	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,			23d. Dat Mor		ery Day Year
о. О	at the de by the a tached	hys	9 Unknown	9□ Unknown								
rds, l	w requires that been signed b should be det	þ	Part II. Other significant conditions or	ontributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.				ibute to t	the cause of death?
Records,	as 2	Completed							24a. Was an autopsy performe	d2 5		oppsy findings available ompletion of cause of
/ita	ysician: The is certificate ha director, page	Be	25. Was case referred to medical examiner?	11		100		of Death (C)	heck only one)			
<del>_</del>	Physi this c	P.	1 ☐ Yes 2 ☑ No 27. Mann of Death	Hospital: 1 Inpatient 2 I	ER/Outpatier		Nurs	-	5 Residence Describe how			fy)
uo	ding l h. After funer	tlon	1 Accident 5 Pending investigation	(Month, Day Year)	Injury	Wor	yat k? Yes 2 □ N		Describe now	injury occur	<del>3</del> 0	
É	al or Attending Physician: : after death.   Diractor: After this certifice d in by the funeral director, I	Certification	3 Suicide 6 Could not be determined		me, farm, str	eet, factory, office		28f.	Location (Stree City or Town, S		er or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral to completely filled	edical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	/sician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and h occurred a	due to the caus it the time, date	se(s) and ma and place, a	nner as s ind due t	stated. o the cause(s)
	To the within ?	Me	29b. Signature and title of certifier			29c. Licens	_		29d	. Date signed	1	Day, Year)
/	X		Mm, MD			00	772	7		12/6	low	
-	7		30. Name and address of person who of Name and address of person who of Name and Address of person who of the Address of the A	NT 201-10		Marel	Necl	lon	l Ess	ed 1	ND	21221
	Sta Registr		31. Date filed (MoTECV, Year) 20	32. Registrar's Signat	400	la de						

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H tificate of L	eaith and M Death		2004 .No.	38626
	Physici		1. Decedent's Name (First, Middle, Las Loretta Cather					2. Date of Death Month December	6, 2004 Year	3. Time of Death 12:30a. M
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	December.	4c. County of Deat	
	Exami		Charlestown Care	Center		Cator	nsville		Baltim	ore Co.
	Funeral Director		5. Social Security Number 6. Social Security Number 1. Social Security Number 6. Social Security Number 1. Social Security	ex □ M 2 1 7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y July 6, 1	ear)   Co	hplace (State or Foreign untry) ryland
	pu .		Usual Residence of Decedent  10a. State 10b. County	10c Cib	v. Town or Lo	nation				10d. Inside City Limits
	a-f ehov	ctor	Maryland Baltimo		tonsvi					1 ☐ Yes 2 💢 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	
	s 23a		1 Keen Valley D				21228		United S	
36	72 hours after death with the Maryland naturel; or Items 23a or 28a-f ehow Jical Exaction to the Incilied at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes of No- Rican, etc.)	14. Race - Ame Black, White Specify:	
9	2 hou		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupa	ation	. 16	b. Kind of Business/	
121	d within 72 giene. ir then "ne Ine Medii	Completed	(Specify only highest gra	College (1-4or 5+)		kind of work done of DO NOT use retired alesperso		ing	Retail	
d 2	illed Hygid other ent, I	Φ	8 yrs. 17. Father's Name (First, Middle, Last)			dresper se		e (First, Middle, Ma		
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg item 27 le marked othe other traumatic event,	To B	Joseph Steiger				Mary	Funke		
Mar	d2sh thanc them traum		19a. Informant's Name/Relationship (7) Sharon Hippler /	**	1	en Valle)			ity or Town, State, 2 . Marylan	
	s 1 and 2 f Health item 27 other tr	00	20a. Method of Disposition	20b. P	And the second section is a second section of the second section of the second section is a second section of the s	sition (Name of natory or other place			c. Location - City or	
E O	Pages nent of B ant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Sac		eart of J	ı	/2004 [	Oundalk, N	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	Michael E. Cana	ipp 22	Name and Address	s of Facility	530	5 Harford timore, MI	Road
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	. Do not ent	er the mode of dying	g, such as cardiac			Approximate Interval Between
	Priysician /Medical	al 1	Immediate Cause (Final disease or condition resulting in death)	a otherose	clan	ticcord	noun	diseas	32	Onset and Death
	Examiner			Due to (or as a consequ	uence of):		a			٥
l.	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uence of):					
	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ionos of):					
8760,	cate be executed obysician and the burial-transit	cai E		Due to (or as a consequ	zence or).					
687	ificate g phys as the	P		, d.						
Вох	death certificate be executed e attending physician and id for use as the burial-transit	an/M	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of deli	*
О. Е	at the dea by the at tached fo	Physicia	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)			Month	Day Year
ď.	de ed	by Ph	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds,	w requires been sign should be							1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
Vital Record	e law has b	ompieted						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
tal	sician: Th certificate rector, pag	e C	25. Was case referred to medical				26 Place of Deatl	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 No
of V	dis y	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Othe			e 6 □Other (Spec	eify)
	ding h. After funel		27. Manns of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? /es 2 □ No	28d. Describe how	injury occurred	
Division	I or Attendi after death. Director: A I in by the fu	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru State)	ral Route Number,
۵	Hospital or . 24 hours after Funeral Dire	O	On Contine 1 Continue Dis	uninion. To the best of an Israel						
	To the Hos within 24 ho To the Fun completely (	edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysicien: To the best of my kno- niner: On the basis of examinal and manner stated.	ion and/or in	estigation, in my op	e, date and place, vinion, death occurr	and due to the caus	se(s) and manner as and place, and due	to the cause(s)
	To the h within 24 To the F complete	×	29b. Signature and title of certifier			29c. License			Date signed (Month	
•	1		manico	$\sqrt{n}$	7	D30	1989	Dø	cember	400S 0)
	р		30. Name and address of person who o	completed cause of death (Item	II. Ma	ister (1	noice. L	o Capa	evilla.	HOS 0
	Sta	-	31. Data filed (Month, Day, Year)	32. Registrar's Signa	The plants	parks		- LAW		**
	Registr	ar	DEC 0 7 2004	A CONTRACTOR OF THE PARTY OF TH	7 /					

State of Maryland / Department of Health and Mental Hygiene 0 38627 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** December 5, 2004 Frances A. Hunter P M 6:40 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ XF Yrs Virginia 220-12-2548 79 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or itama 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 No Beltsville Director Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4650 Quimby Avenue 20705 USA deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status filed withIn 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry University of al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maryland Administrative Secretary permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 Is marked other It any injury or other traumatic event. The Once. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lutie Virginia Marcus William Marcus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Hunter/Daughter 2801 Hansen Lane, Finksburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12/7/2004 Odenton, MD <sup>1</sup> 4 □ Donation 5 □ Other (Specify) West Arundel Crem. 21. Signature if Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 M00773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hemorrhagic Stroke 3 days /Medical Due to (or as a consequence of): **Examiner** Stroke from arterial infarction 4 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and al-transit The law requires that the death certificate be executed years Hypertension Due to (or as a consequence of): ed by the attending physicien a detached for use as the burial-P.O. Box 68760 Physician/Medical Chronic atrial fibrillation years IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Pernicious Anemia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan has autopsy performed? certificate 1 ☐ Yes 2 XNo Division of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Malignation 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 5 Pending after death.

Director: Af
in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral D 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D39532 Ø 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy P. McClain, MD 321 Prince George Street, Laurel, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2004

				• -		partment of Health and I 07:04 th ertificate of Death	Mental Hygier	3	38628		
	Physici		Decedent's Name (First, Middle, L LEONARD H. HEN	ast)	-		2. Date of Death Month	Day Year	3. Time of Death		
5	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or Location of Deatl	November	4c. County of Death			
			Greater Baltimor	e Medical (	Center	Towson	I	Baltimore			
	Funeral Director		5. Social Security Number  6. Sex 1 X M 2 F 82 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 1 0 - 20 - 1922 MA								
	death with the Maryland ms 23e or 28e-f show Errust be rediffed at	٥٢	Usual Residence of Decedent		10c. City, Town o				10d. Inside City Limits 1 X Yes 2 □ No		
	r 28a-	Director	10e. Street and Number			10f. Zip Code	10g. Citizen of What Co				
	th with		3326 BURLEITH A	VE.		21215	21215 USA				
036	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or Items 23e or 28a-f show event, I'm Medical Exaciliser must be rediffed at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puert     □ Yes 2 X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americen Indian, Black, White, etc. Specify: BLACK			
9500-6121	within 72 hours after ene. then "neturel", or Ite	Completed	15. Decedent's ( Specify only highest g	ducation rade completed) College (1-4or 5	rking 16b.	Kind of Business/li	ndustry				
N	filed wil Hygien sther th	Con	-10-	-0-		BORER		BETHLEHEM	STEEL		
Maryland		To Be	17. Father's Name (First, Middle, Las EDWARD HENDERS			HELE	ne <i>(First, Middl</i> e, <i>Maid</i> N FORD				
_	12 tr		19a. Informant's Name/Relationship VANESSA HARRY (			ailing Address (Street and Number or Ru KENT AVE. MARLTON			ip Code)		
Baitimore,	80		20a. Method of Disposition 1 ∑ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Di cemetery,	sposition (Name of prematory or other place) 12-1	_20c.	Location - City or T	own, State		
	t. Pages nment of I nent: If its njury or o		`4 ☐ Donation 5 ☐ Other (Spec	ify)		FOREST VETERANS			, MARYLAND		
<u>a</u>	permit. Pag Department Importent: any injury o		21. Signatur - Weral Service Lic	O. HiB	new	图 Name and Address of Facility RE 1721-27 N. MONROE	ST. BALTIM		LAND 21217		
,	Physician /Medical		23a. Part1/Efter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Res	piratus	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Conset and Death		
	Examiner	-		Re	consequence of).	ailure_		mosities			
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any leading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G.	otension				years		
68/6U,	cate be ex physician the buria	cal		·	betes						
. Box	the death certificate be executed y the attending physician and sched for use as the burial-transit	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	23d. Date of deliv Month	rery Day Year					
coras, r	w requires that the de baen signed by the should be detached	by P	Part II. Other significant conditions	ons contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to							
Hec	e la has	ompleted					24a. Was an autopsy performed?	death?	opsy findings available ompletion of cause of		
	ysicien: The is certificate director, pag	BeC	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)	10 103	2,110		
on or v	S S D	၉	1 Yes 2 100  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatie  28a. te o Injur (Month, Day	y 28b. Time	of 28c. Injury at	ome 5 Residence 28d. Describe how in		fy)		
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not determined	be ass Steep of Lois	ury - At home, farm, c. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rur ate)	al Route Number,		
	ne Hospil 124 hour 18 Funera Jetely fille	edical (	29a. Certifier (Check only one)	hy <b>sicia</b> n: To the best o miner: On the basis of and manner sta	examination and/or	eath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due t	stated. to the cause(s)		
	To the within the composition of	M	29b. Signature and title of certifier	m		29c. License number	29d. C	Date signed (Menth,	Day, Year)		
			30. Name and address of person who	confipleted cause of de	eath (Item 23a) (Typ		2,204	1	,		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 7 2004	32. Registra	ur's Skinature	all					

			1 - For State Registrar		State of M		epartment of Certificate	of Health and of Death		giene Reg. No.	04	38629	
			1. Decedent's Name (First, Middle, Last)  2. Date of Death									3. Time of Death	
	Physic		Edwin H	Hobart Ho	dsdon				Month 12	Day	Year	3:15 P <sup>M</sup>	
	/Medi Exami		4a. Facility Name (If I			)	4b. City, To	wn, or Location of Dea		4c. Cou	2004 Inty of Death	J.1J F	
1			Wilson	Healthca	re Center		Car	thersburg					
	Funeral	_	5. Social Security Nu			ge (In yrs. last birthe	(ay) If Under 1 '	ear If Under 24 Hr		h	Iontgom	lery lace (State or Foreign	
	Director		167-03-8	384	<b>∑</b> M 2□F	98 Yr	Months E	ays Hours Mir	n. (Month, Da 10/25/	y, Year)	Coun	try) MA	
	D .		Usual Residence of Decedent						10/25/	1900		MA	
	nylan how		10a. State	10b. County		10c. City, Town of	r Location				10	Od. Inside City Limits	
	a-f e	Stor	MD	Montg	omery		G	aithersbur	1 ☐ Yes 2 XNo				
	th th	lre	10e. Street and Numl	ber			10f. Zip Co			10g. Citizen of What Country?			
	th wi	al	333 Rus	sell Ave	nue Ap	t. 406		20877		USA			
	72 hours after death with the Maryland naturel', or tems 23e or 28a-f ehow disel Examiner must be notified at	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Deceden	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No		Race - America		
9	or It	F	1 Never Marrie	_	1 ☐ Yes 2 📉 If Yes, Give		1 ☐ Yes 2X		nto Alcan, etc.)		Black, White, e	etc.	
8	irel',	d by	3	Divorced	Year or Dates:		1 🗆 105 2 🗛	No Specify:		Spe	cify: Wh:	ite	
215-0036	72 h natu	Completed		15. Decedent's Ed		16a. D	ecedent's Usual D	ccupation	orkina	16b. Kind o	Business/Ind	lustry	
2	within in the series of the se	ם	Elementary/Second	dary (0-12)	College (1-4or	5+)		one during most of wo stired)	g				
21	filed withi Hygiene. other then ent, the M	S			4	S	ales Exe					Company	
p	d ta b	Be	17. Father's Name (F	irst, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sun	name)		
× a	should be and Mental I	မ	Charles	Edwin H	odsdon			Edith	Sawyer				
Maryland	01 00 00		19a. Informant's Nam	ne/Relationship (7	Гуре, Print)				lural Route Numbe	or, City or Tox	vn, State, Zip	Code)	
_	1 and 2 Health tem 27 i				/ daughter			er Lane,	Boyds, Ma	arylan	d 20841	L	
altimore,	0 0		20a. Method of Dispo		Removal from State	20b. Place of D cemetery,	sposition (Name or other	place)	Date	20c. Location	n - City or Tov	wn, State	
Ē	Pag nent int:		`4 □Donation 5	Other (Specify	)			Park 12/	6/2004	Glen	Burnie	. Marvland	
att	permit. Pag Department Important: I any injury o		21. Signature of Fund	eral Service Licen				ddress of Facility					
m	90 = 99	10 1	Mar	h K. Vas	reure A	101357	1	Second Av	enue, SW	Glen	Burnie	MD 21061	
			23a. Part1. Enter the shock, or heart	disease, or comp	olications that caused one cause on each li	d the death. Do not	enter the mode o	dying, such as cardia	c or respiratory ar	rest,		Approximate	
	Physician		Immediate Cause (Fi		Congestive heart failure 300								
	/Medical		resulting in death)		Due to (or as	a consequence of):		Contra				Janes .	
	Examiner		Sequentially list cons	ist conditions. b. aschemie cardeomyapathy									
	D #	ner	Sequentially list cond if any, leading to immo cause. Enter Underly Cause (Disease or in	nediate	Due to (or as a consequence of):								
	cute nd irans	Examiner	that initiated events		caron	rangas	lesy	rollar	e/				
O O	e exe		resulting in death) La	st	Due to (or as	a consequence of):	1						
68760,	ficate be executed physicien and is the burial-transit	edlcal			d								
		Med	IE EEMALE.										
Вох	law requires that the death certific as been signed by the atlending t 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent p	nognani	23c. If yes, outcome	of pregnancy 2 Fetal death	3 □Ectopic pregn	ancy		23d. [	Date of deliver	у	
	dea ne att	sicie	in the past 12 m 1 ☐ Yes 2 ☐ i		4☐Pregnant at		5 Other (specif			1	Month [	Day Year	
P.0	that the de led by the detached	hy	9 🗆 Unknown										
	res tha signed b	by F	Part II. Other signification						23e. Did to	bacco use co	ontribute to the	cause of death?	
Records,	w require been sig should b	ed	home	cottel	enclia	e poeter	man	Lacrea	26 1 Y	es 2.⊉No	3 🗌 Proba	bly 4 Dunknown	
00	aw requast been 2 should	ompleted	Carcin	mach	prosto	ate. 44	ridly	willation	2 24a. Was a	ın 24t	. Were autors	sy findings available	
æ	و ي و	Шo	(himi-	lym	1: 4	: losel			autop: perfor	sy med?/	prior to com death?	pletion of cause of	
Vital		e C	25. Was case referred		diverge	car	eme		1 ☐ Yes ath (Check only or		1∐Yes 2	!□ No	
		OB	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1  Inpatie	ent 2 ER/Outpa	tient 3 DOA	0.1			- 99		
of	ding Phys h. After this funeral di	<u> </u>	27. Manner of Deeth		28a. Date of Inju	ry 28b. Tim		njury at Work?					
Division	Attending I r death. ector: After by the funer	ertification;	1 ☑Natural 2 ☐ Accident	5 Pending investigation	(Month, Da	y Year) Inju		Work? 1 □ Yes 2 □ No		, ,			
is!	Attendi death. ctor: A y the fu	fice	3 🗀 Suicide	6 Could not be determined	28e. Place of Inju	ury - At home, farm,			28f. Location (S	Maryland 20841  20c. Location · City or Town, State  Glen Burnie, Maryland  ton Funeral Home, P.A.  W Glen Burnie, MD 21061  Approximate Interval Between Onset and Death  Year  23d. Date of delivery Month Day Year  d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  as an topsy frormed?  24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  y one)  asidence 6 Other (Specify) be how injury occurred  a. (Street and Number or Rural Route Number, own, State)  1 Occurred  Cause(s) and manner as stated.  B. date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)  Cause (Specify)  Cause			
Š	afte Dire	building, etc. (Specify)								n, State)		i da i vambor,	
	spitt nours nerel	alc	29a. Certifier 1	Certifying Phy	rsician: To the best	of my knowledge. de	ath occurred at the	e time, date and place	and due to the o	auso(e) and	nanner se etc	tad	
	e Ho 24 h e Fu, letely	dical	(Check only 2 one)	☐ Medical Exam	iner: On the basis of and manner sta	examination and/o	investigation, in r	ny opinion, death occu	irred at the time, d	ate and place	and due to t	he cause(s)	
	To the Hospital or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and titl	le of certifier			29c. Lic	ense number	2	9d. Date sign	ned (Month, Da	ay, Year)	
	> - 0		1 StoRa	Kuth	weekle	xxbuss		04115		A.		/	
	N		30. Name and address	s of person who o	ompleted cause of d	eath (Item 23a) (Tim	a Print\ 7					,	
	0		W.ROBER	7 BIRS	HBALLI	116 (19)	2. A	(THED A)	LAVE, MI	11 50	877		
	Sta	te	31. Date filed (Month,			ar's Signature	4	· 11-200	chej was				
	Registr	_	D	EC 07 2	004 50	meren 1	9 hou	estal.					

State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year 108 **Physician** a N December 2004 Jean Elizabeth Hooper /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Marylana GreneRal Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 1 F Yrs. 68 Director Nov 18, 1936 215-34-9178 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. Count 10c. City, Town or Location 10a. State or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No by Funeral Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 United States 2267 Madison Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify. 3 Novidowed 4 Divorced 'naturel' Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health Care it of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Housekeeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be William Edward Waters, Sr. Rosella Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin T. Waters/Son 701 Hummel Avenue, Leymone, PA 17043 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Dec 6 permil. Page Department of Importent: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) 2004 Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MO0986 Cremation and Funeral Alternatives 4 8717 Green Pastures Drive Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final le tastat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4□ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 100 1 Yes 1 ☐ Yes Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Inpatient P 2000 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral Mate of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No death. within 24 hours after death.

To the Funerel Director: A completely filled in by the f 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Pgint) M.U. 32, Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 07 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 38631 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1 **Physician** 600PN 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 20 South Ellwood Avenue N/A Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min. Hours 1 MM 2□ F 52 Yrs. 217-27-8365 Feb 6, VA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count r than "natural", or Itams 23s or 28s-f show the Medical Exeminer must be notified at 1 X Yes 2 No Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 United States 20 South Ellwood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hospitality Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 Is marked other that any injury or other traumatic event, Italy once. Entertainer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willis Hardy Virginia Fine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8903 Jeff Mar Drive, Glen Burnie, MD 21061 Eric K. Lerner/Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dec 4 2004 Baltimore, MD Trinity Cemtery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M00986 Loule 8717 Green Pastures Drive Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final FAILURE **Physician** disease or condition resulting in death) MONUTH /Medical Due to (or as a consequence of): Examiner C INFECTION 20 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certiticate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy igned by the atter Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: rector, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3 DOA 1 Tyes 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely tilled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 037168 mar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE R.E. CHAISSON, MO HOPKINS HUSPITAL JOHNS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 07

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 0 1 38632 1 - For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2:15 Pm. Dec 1, 2004 Rachel E. Jiles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore N/A Joseph Richie Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 SC. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 3<sub>6</sub>□ F Months Hours Min. Yrs. Director 68 Nov 25, 1936 213-30-2797 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show r then "naturel", or Items 23e or 28a-f sho the Medical Examinar must be notified at 1 Yes 2 No Raltimore Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21223 400 Millington Apt# 324 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify Black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Best Western Hotel Elementary/Secondary (0-12) Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F Pages 1 and 2 should be Minnie Eady Booker T. Eady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Spartment of Health ar, Importent: If item 27 Is n any injury or other: 2518 W. Pratt Street Baltimore, Maryland 21223 Barbara Barnes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/06/04 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place. Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Metastu Physician MOUTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 Pr No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Vita 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Ner (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Inpatient 2 1 Tyes Division of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of 27. Manner of Death Certification: After To the Hospitel or Attending 1 atural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 Thomicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of contifier e and address of person who/completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filod (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#11, perINE 6838, 12/23/04 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 3, **Physician** 2004 Wilbur A. Johnson 02:35 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall 8. Date of Birth (Month, Day, Year) 2 2 17, 1919 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Washington DC 579 14 3642 85 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23a or 28a-f show Ever it er must be cotified at 1 Yes 2 No St. Mary's Charlotte Hall Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20632 United States permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Items 23a any injury or other traumatic event, the Medical Ever, fiver must once. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

\*\*TYPES 2 No WW ] 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💥 o Specify: Specify: þ 3 Widowed Divorced 16b. Kind of Business/Industry ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Compi College (1-4or 5+) Elementary/Secondary (0-12) **GSA** Operating Engineer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Frank Wilbur A. Johnson ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 9318 Pineview Lane , Clinton, Maryland 20735 Frances Tucker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Resurrection Cemetery Clinton, Maryland Donation 5 Other (Specify) 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licenses 4001 Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final witery **Physician** commence disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b Irrector, page 2 s autopsy 2 No Demente Yes 25. Was case referred medical 26. Place of Beath (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 26 No Certification: To 1 Tes 2 ER/Outpatient 3 DOA within 24 hours after deam.
To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 200 60120 MONTA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagethman A. Wall

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

DEC 07 2008

**ORIGINAL** 

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygienen () [ 38634 1 - For Stata Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 300 Curtis James Janzen 2004 /Medical 4a. Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F Days Min. Hours 74 Yrs. Director 506-24-6036 Feb 9, Nebraska Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 XYes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Charles Street, Apt. 307 or Itams 23a 4100 N. 21218 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No <u>ک</u> 3 Widowed 4 Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Higher Education permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is markad other than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Janzen Helena Wiebe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Scott Janzen/Son 4100 N. Charles Street, Apt. 309, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec 8 ö injury \* 4 □ Donation 5 □ Other (Specify) Beltsville, MD Chesapeake Crematory 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M00986 any Baltimore, 8717 Green Pastures Drive MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10/010 MATO disease or condition resulting in death) /Medical r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executed) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ŏ Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4. Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate Division of Vital 1 Yes 1 Yes the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 CA/Outpatient 3 DOA 2 1 🗌 Yes 2 No 1 Inpatient this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1\_Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person of ompleted cause of death (Item 23a) (Type, Print) Union 31. Date filed th, Day, Year) 32 Registrar's Signature State DEC 07 2004 Registrar

State of Maryland / Department of Health and Mental Hygiepen 38635 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year PATRICIA JACOBY 3,50 PM 04 /Medical 04 4a. Facility Name (If not institution, give street and number) CENTER 4b. City, Town, or Location of Death **Examiner** 4c. County of Death POTOMAC VALLEY NURSING AND WELLNEY Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min 74 395-24-9654 Director 16, Wisconsin Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f ehow any injury or other treumetic event, the Medical Examinar Mast be netitied... once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☐ No Maryland | Montgomery Poolesville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 17630 Kohlhoss Rd. 20837 United States 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2☐XNo fYes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Specify: White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Wendt Sophie Politoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Jacoby / Husband 17630 Kohlhoss Rd., Poolesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Temation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/7/04 Beltsville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Rapp Funeral and Cremation 933 Gist Ave., Silver Sprin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rapp Funeral and Cremation Service 933 Gist Ave., Silver Spring, MD Cremation Service Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOPULMONARY **Physician** ARREST /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the trace. Extra darking Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILL ATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed; 1 Yes 2 X No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Certification: To 2516 1 🗌 Yes Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel [ To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifief 29c. License number 29d. Date signed (Month, Day, Year) 12/04 D0061959 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMAN SIBAL 1299 M. D LAMBERTON DR SILVERSPRING MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 07 2004

State of Maryland / Department of Health and Mental Hygiene 004 38636 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** DECEMBER 3, 2004 DOROTHY **JOSEPHSON** 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) MAR.4,1915 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Hours 214-03-6137 89 Yrs. Director VA Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at Director 1 Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2500 W. BELVEDERE AVENUE #806 Items 23a 21215 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Completed by 1 ☐ Yes 2 🏋 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE "natural", 2 should be filed within 72 h and Mental Hygiene. Is marked other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **MEYER** KERN 2 LENA SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: ff item 27 Is n any injury or other traun <u>once.</u> MYRA WITTIK / DAUGHTER 3942 CHAFFEY ROAD - RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation BNAI ISRAEL CEMETERY 12/05/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Immediate Cause (Final 22 DAYS Physician FALL AND VETEBRALBODY FRACTURE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** 7 DAYS RENAL **FAILURE** Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence on burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760 The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe Division of Vital 1 ☐ Yes 2 🗖 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. I hours after death uneral Director: 2 XAccident NOV. 11, 2004 2 1 ☐ Yes 2 ☐ No FELL WHILE WALKING Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

8500 Nor BELLY DERE AVE. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide AT HOME Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of pertitler 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN D0057459 DECEMBER 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID BEKELMAN, MD., 6601 N. CHARLES ST. TOWSON, MARYLAND 21204 2004 32. Registrar's Signature State Registrar

		Please  1 - State Registrar	State of Marylar	nd / Depa		Health and Me	-	•	38637
Physicia /Medic Examina	al	Decedent's Name (First, Middle, Li Helen Lydia K     4a. Facility Name (If not institution, git Gilchrist Center	rebs ve street and number)		4b. City, Town,	or Location of Death	2. Date of Death Month December	Day Year 3, 2004 4c. County of Dea	3:30 P M
Funeral Director		5. Social Security Number 6.	Sex 1 M 2 F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Ye		irthplace (State or Foreigr Country) ULYLAND
the Maryland 28a-f show	Director	10a. State 10b. County  Maryland N/A  10e. Street and Number	10c. Ci	ty, Town or Lo	cation  Cultimore  10f. Zip Code		10g.	Citizen of What C	10d. Inside City Limits 1   Yes 2  No Country?
er death v	Funerai	5709 Adleigh Au  11. Marital Status  1 □ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 \( \text{Yes} \) 2 (\( \text{X} \) No If Yes, Give	.S. 13.	Vas Decedent of Yes, specify Cu	21206 Hispanic Origin? (Speban, Mexican, Puerto F		U.S.A 14. Race - Am Black, Wh	A. nerican Indian,
Maryland 21215-0036 its and 2 should be filled within 72 hours att fill and Mental Hygiens 77 is marked other than "naturel", or treumatic event, the Medical Exercitive	Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Year or Dates:	16a. Deced (Give life.		upation e during most of workin ed)	ig .	Specify:	s/Industry
yland 21 uld be filed wi Mental Hygien arked other th	To Be Con	12th Grade  17. Father's Name (First, Middle, Las  John R. Vitak		Exec	utive Se	ecretary 18. Mother's Name Elena		•	[ndustry
ore, Marres tend 2 shoof Health and 2 litem 27 is murred theuth and 10 the treum		19a. Informant's Name/Relationship  Charles L. Krebs  20a. Method of Disposition  1 ▼Burial 2 □ Cremation 3 I	(husband)	5709		at and Number or Rural  A AVENUE, A  (ace)	pt. B-5,		MD 21206
Baltimore, permit. Pages 1 er Department of Heal Importent: If then a my injury or other once.	and the same of th	4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	ity) Gar	dens o	f Faith . Name and Add	Cem. 12/7/ ress of Facility Sch Lair Rd., B	imunek Fi	ineral Ho	omes
Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the deal one cause on each line.  a	atic			respiratory arrest,		Approximate Interval Between Onset and Death Mon 1720
760, te be executed spicion and se burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d.						
	Physician/Med	IF FEMALE: 23b. Was decedant pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	23c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	ıl death 3 🗀	Ectopic pregnan Other (specify)			23d. Date of de Month	elivery Day Year
cords, P.O. v requires that the de been signed by the s should be detached	2	Part II. Dther significant conditions	contributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did tobac 1 ☐ Yes		to the cause of death?  Probably 4 □Unknown
Vital Recc	Completed						24a. Was an autopsy performed 1 Yes 2	prior to death?	autopsy findings available completion of cause of s 2 No
Division of Vital Records, P.O. Box I or Attending Physician: The law requires that the death cert after death.  Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use.	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. In		(Check only one)	-	ecity)HUSPIC
Divis	i Certification;	3 Suicide 6 Could not to determined	building, etc. (Special	(y)			City or Town, S	îtate)	Rural Route Number,
Division of To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only one)  29b. Signature and title of certifier	hysician: To the best of my knominer: On the basis of examina and manner stated.	ition and/or in	restigation, in my	opinion, death occurre	d at the time, date	and place, and du	nth, Day, Year)
		30. Name and address of person who	completed cause of death (Iter	п 23а) (Туре,	Print)	58303			rles Street
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature A	1		Tow	son, Mxd	-21204

State of Maryland / Department of Health and Mental Hygie Pen 1 L 38638 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 4, 2004 **Physician** 11:40 A M John William Kendall /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3630 Eastwood Drive Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Min. Warch 4, 1920 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 220--01-6118 Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State r Items 23a or 28a-f show dreft - ust be notified at Maryland N/A Baltimore 1Y Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3630 Eastwood Drive 21206 USA Pages 1 and 2 should be filed within 72 hours after death : nent of Health and Mental Hygiene. int: If item 27 is marked other than "naturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 TWes 2 □ No WIII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dye Setter Continental Can 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Marshall Doris Alexander 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i M. Elaine Kendall/Wife 3630 Eastwood Drive Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State ō = 5 1 Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) rtment rtent: If njury o Parkwood Cemetery 12/07/04 Baltimore Maryland permit.
Departm
Importe
any inju 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Metastones **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Tyes the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only or Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 024356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) We in bey Concer Center Wm C WATERFIELD MM 9103 Frankle Sy & Bal 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

DEC 0 7 2004

			1 - For State Registrar	State of M	aryland	/ Depa	artment of H	lealth an Death	nd Men		2004	38639	
	Physici		1. Decedent's Name (First, Middle, Last	Knac	ses				_ I	Date of Death Month	Day Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of [			4c. County of Dea		
			Riverview Nursin				Essex				Baltim	ore	
	Funeral Director		168-18-3406	x 7. Aç □M 2⊠F	ge (In yrs. Ia: 96	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (	Date of Birth Month, Day, Y INUARY	<sup>9. Bir</sup> 19,1908	thplace (State or Foreign ountry) Penn	
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
	Mary a-f sh	tor	Maryland N/A			Balt	imore Cit	у				1 ☐ Yes 2 ☐ No	
	with the 3a or 28s	Il Direc	10e. Street and Number 5109 Holder Aven	ue			10f. Zip Code 21214			100	J. Citizen of What C	ountry?	
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show office Extending the neithfold	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tes 2 If Yes, Give Year or Dates:	?		Was Decedent of H f Yes, specify Cuba  1 ☐ Yes 2 ☒ No	ispanic Origin n, Mexican, F Specify:	n? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - Am Black, Whi		
5-0	72 hc	Completed	15. Decedent's Edi (Specify only highest grad	ication le com <i>pleted)</i>		(Give	dent's Usual Occup	during most of	of working	16	Sb. Kind of Business	/Industry	
121	within ene. than "	Id III	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retired	()			066:00		
	filed v Hygie othar t	CO	12 yr¹s			800	okkeeper	18. Mother's	s Name (Fir	st, Middle, Ma	Office		
Maryland	ges 1 and 2 should be filed within 72 hc to f Health and Mental Hyglene. If itam 27 is marked othar than "natur or other traumatic evant, Its McAlcal	To Be	George	J.	Proe:			An	na		M.	Schappacher	
Mar	and 2 sh ealth and m 27 ts m		19a. Informant's Name/Relationship (T) Francis J. Knauer				ng Address <i>(Street :</i> 35 Kent D				City or Town, State, Delaware		
Jre,	es 1 a of Hea fitam rothe		20a. Method of Disposition	S	con	ce of Dispo	sition (Name of natory or other place	e)	Date	1	c. Location - City or	Town, State	
<u><u>Ë</u></u>	Page ment ant: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify)			Park	-	1	2/4/0	4	Baltimore	, MD	
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 eny injury or other tr 9009.		21. Signatur of Funeral Service Licens	en toral	fr		Name and Address		Balt Inc.	imore, 5305	Maryland Harford	21214 Rd.	
r			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause ne cause on each	d the death.	Do not ent	er the mode of dyin	g, such as ca	ırdiac or res	piratory arres	t,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hypunt			iniosclu	The Co	OTENO	- Carenal	lac Dues	Years	
	Examiner			Due to (or as	a conseque	nce of):							
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	nce of):							
	be executed sician and burial-transit	Examiner		c Due to (or as	a conseque	nce of):							
8760,	ate be ex hysician the burial	dlcal E	l	d									
9	tificate ng phys as the	Medi	15.55141.5										
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal d	eath 3□	Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year	
Δ.	ires that signed b		Part II. Other significant conditions co	ntributing to death t	out not result	ing in the u	nderlying cause give	en in Part I.				o the cause of death?	
orc	w requir been si should	eted	0 / 1						-				
Il Records,		Completed by	tarlies nes 4-						-	24a. Was an autopsy performe 1 ☐ Yes 2 €	prior to	utopsy findings available completion of cause of	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Cth		Death (Ch	eck only one)			
of	S S	<u>۲</u>	1 Yes 2 No 27. Manner of Death	1 L Inpati	ent 2 El	R/Outpatien 8b. Time of		4 Ursii			injury occurred	cify)	
on	Attending r death. actor: After by the funer	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ay Year)	Injury	Work	k? Yes 2 □No		000010011011	injury occurred		
Division	or Atter ifter dea Diractor in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At hom tc. (Specify)	e, farm, str	reet, factory, office 28f. Location			ocation (Stre	n (Street and Number or Rural Route Number, Town, State)		
3	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowl	edge, death	occurred at the tim	ne, date and p	place, and d	due to the caus	se(s) and manner as	s stated.	
	thin 2, the F	Medical	one) 29b. Signature and title of certifier	and manner st	tated.		29c. License				. Date signed (Mont		
	T V		Marena Co	wares	>		DIA						
•	n		30. Name and address of person who c	ompleted cause of	death (Item 2	23a) (Type,	Print)			(	2-02-20 OCEN BUR	NIEMO	
	¥		MICHAEL SHWA	RTZ, MI	) 7:	310 1	RITCHIE H	lwy s	STE S	08	2	1061	
:	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 7 2004	Seres 32. Registi	rar's Signatur	re Sp	rocks!	,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie Pen n L 38640 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KAMASINSKI GERTRUDE 9130 AM NOVEMBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Ctr. Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🔀 F Director 216-12-7480 Maryland April 17,1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 ☐ Yes 2 XNo **Funeral Director** Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 Delbert Avenue Itams 23a 21222 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: Completed by 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should ba f nent of Health and Mental H int: If itam 27 Is markad ot 2 Anthony Czyryca Nora Czynski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Kamasinski/Son 17 Lark Meadow Court Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State = 5 Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Mary Cem. 11/27/2004 Dundalk, Maryland 22 Name and Address of Facility Duda-Ruck funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Lipensee Con 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician BLEE /Medical Due to (or as a consequence of) Examiner VALVE Sequentially list conditions, I any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit AORTIC INSUFFICIENCY The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760, ANAENLIA Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month ō in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 2 (2)No of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death Diractor: 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 2 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

29b. Signature and title of x rtifier

NOUR, SEE THE MD

SEEMA NOW, 4940 EASTERN AVENUE, BALTIMORE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

NOVEMBER, 23 2004

MD 21224.

State of Maryland / Department of Health and Mental Hygter 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Dey **Physician** December 6, 2004 REGINA KELLY 7:55 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner Catonsville Baltimore St. Joseph Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 1□M 2×F Funeral Yrs. Director August 14, 1910 Michigan Usuel Residence of Decedent pamit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Dapartmant of Health and Mantel Hygiana. important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21045 Funeral 6482 Summer Cloud Way 12. Was Decedent Ever in U,S. Armed Forces 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banking Bank Employee 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Walsh Joseph Andrew Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Ms. Carol Hayes-Gegner Niece
20a. Method of Disposition

12 Buriel 2 Cremation 3 Removal from State 6482 Summer Cloud Way Columbia, Maryland 21045 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete cemetery, crematory or other place) 4 ☐ Donetion 5 ☐ Other (Specify) 12/11/2004 Southfield, Michigan Holy Sepulcher 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feligre. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death cartificate be executed attanding physician and I for usa as tha burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of): signad by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No diractor, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 : Aftar this a funaral dir 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 🗌 Pending 1 Natural To the Hospital or Attendin within 24 hours aftar daath.
To the Funeral Director: Af complataly filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide edical 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature-and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, 32. Registrer's Signature 2004

30. Name end eddress of person who completed cause of deeth, (Item 23e) (Type, Print)

**DHMH 16 Rev 6/95** 

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State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3 M mble 111 )ec 2004 /Medical 4c. County of Death 4a. Facility Name (If not institu 4b. City, Town, or Location of Death Examiner Saltimore TONA VICK If Under 1 Year | If Under 24 Hrs. 8. 8. Date of Birth 6 / 26 / 1958 5. Social Security Number 6. Sex 7. Age (In yrs Birthplece (State or Foreign Country) **Funeral** Days Min. Hours 1 ☐ M 2 🛣 F 46 MD 235-80-8230 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or items 23a or 28a-f show Evanding must be notified at MD Anne Arundel Baltimore 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5601 Patrick Henry Drive 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify white Completed by 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Food Industry if Health and Mental Hygiene. Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elwanda Lee McDonald Kenney Kimble Willard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1012 Minnetonka Rd., Severn Mrs. Phyllisann E. Landis/Aunt MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State Maysville Cemetery 12/11/04 Maysville, W.Va. • 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Runeral Service M01364 1 Second Ave SW Glen Burnie MD 21061 la 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Phyaician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ŏ Day 5 Other (specify) ☐Yes 2☐No detached f 9 Unknown 9 Mnknown ፩ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed g 2 200 3 Probably 4 Unknown 1 ☐ Yes filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner?
1 ∠Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 3 DOA 2 ER/Outpatient After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending investigation 1'SaNatural 1 ☐ Yes 2 ☐ No М death. 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eputy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1//iAm o wes 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2004

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygions 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician December 5, 2004 Edward C. Lauber 11:57 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City, Town or Location of Death Examiner Upper Chesapeake Medical Campus Bel Air Harkord 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours 714-05-6871 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits "natural", or Itams 23a or 28a-f show alcal Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Bel Air Maryland Harkord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 Crocker Dr., Apt. E 21014 U.S.A. 12. Was Decedent Ever in U.S. Amped Forces? 1 (∆Yes 2 □ No If Yes, Give Year or Dates: WW 11 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic evant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Hauling 9th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lauber Henry Marie Haschert ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is any injury or other traun Mr. C. Walter Haschert (cousin) 439 Hook Road, Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem'l 12/9/2004 Timonium, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2VNo 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air Maryland d 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygier [ ] 38644 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Theodore Frank Lind 8:50 FM ECEMBER 2004 3. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**XM 2□ F Belize 80 265-38-0681 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Worcester Ocean City 1 Yes 2 □ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 116 Nautical Lane 21842 United States Itema 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status the Medical Examiner 1 □ Yes 22☑No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 6 1 Yes 2 No Specify: Completed by 3 XWidowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Davidson Transfer Co. traumatic evant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Health and Mental tem 27 is marked o Maud Lind Sebastian DR. Herbert Lind 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Katherine Broda (Daughter) 9619 Ninth Avenue, Baltimore, Maryland 21234 other t 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō = 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Druid Ridge Mausoleum 12/07/04 4 □ Donation 5 ₩ Other (Specify) Entombment Pikesville, Maryland 22. Name and Address of Facility Loring Syers Funeral Directors 21. Sign very of Funeral Service Lice see 8728 Liberty Road, randallstown, Md. 21133-4784 1400 333 ellner 23a. Parn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MANTLE CELL LYMPHOME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 🗆 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 21X No 2 🗆 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 Tyes 2 🗆 No Diractor: 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide pellil within 24 hours a To tha Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number m-ella m.c Decamber Zurl OB 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 OSLER DRIVE, TOWSON, MARYLAND 21204 32. Aegistrār's Signature State Registrar 2004

Anna Leader 04-7690 AKG

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State of Maryland / D

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	Physici /Medic			Anna	Mae	Leader		Novembe		2 <b>00</b> 4	12:00 P M
	Examin	er	4a. Facility Name (If not institution, give Johns Hopkins Bayy		-01	4b. City, Town, o	or Location of Death		4c. County		
			5. Social Security Number 6. Se		-à⊥ (In yrs. last birthday)			8 Date of Birth		N/A	place (State or Enrojan
į,	Funeral Director		213-32-1382 Usual Residence of Decedent	□M 2□F 6	Vec	Months Days	Hours Min.	8. Date of Birtl (Month, Day Dec. 2	, Year) , 1936		place (State or Foreigr ntry) ryland
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	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23a	ral	6819 Belclare				21222		United		
	er de	nne	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	can Indian, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show eny injury or other treumetic event. The Madical Examinar must be nutilied at once.	by Funeral	Never Married 2☐ Married  3☐ Widowed 4☐ Divorced	1  Yes 2  No If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specif	y: Wł	nite
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Maryland	d be sontal	To Be	George Leader						tina Hi	,	rand
چ	should be nd Mental marked c	F	19a. Informant's Name/Relationship (7	уре, Print)	19b. Mail	ing Address (Street	and Number or Rura	al Route Numbe	r, City or Town	, State, Zip	Code)
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ore,	es 1 a of He of He fitem r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Pamoval from State	20b. Place of Disponentery, cre	osition (Name of matory or other pla	се)	Date	20c. Location	- City or To	own, State
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	Sta	te	Carol Allan MD  31. Date filed (Month_Day_Year)	32. Registrar			altimore,	Mary⊥an	d 2120	丌	
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Phys	cian		pend Item	t)		· <u>-</u>	tificate of	Death	2. Date of De	ath		38646
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Funer Directo		5. Social Security 217-60	Number 6. Se -4025	ex M 2□F	7. Age <i>(In yr</i> s. 5 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min	s. 8. Date of Bir	th	9. Birt	hplace (State or Foreign buntry) cyland
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Ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than "natural", or items 23a or 28a-f show event, it a Mudical Evantiner must be notified at	by Funeral	11. Marital Status		12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	ces? 2 [ <b>X</b> No e		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Specify Yes or No rto Rican, etc.)		14. Race - Ame Black, Whit	e, etc.
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of this aldi	Certification; To Be	25. Was case ref examiner? 1 X Yes 2 [ 27. Manner of De 1 Natural 2 Accident 3 Suicide	□No	Found Found	f Injury n, Day Year) 2004	28b. Time of Found	28c, Injury Work P M 1 🗆 Y	er: 4 ☐ Nursing	Home 5 Resident Resid	dence (	y occurred <b>U</b>	sity) SCENE
Division ( To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.		4  Homicide	datamainad	Scene	g, etc. (Specil	(y) 	eet, factory, office	no data ced el-	Middle	Rive	r, Md	ral Route Number, eter Dr.
o the Hos vithin 24 hd o the Fun ompletely	Medical	(Check only one)  29b. Signature ar	2 <u>X</u> Medical Exam	iner: On the ba	sis of examina	ation and/or inv	estigation, in my op	oinion, death occ	urred at the time,	date and	and manner as I place, and due e signed (Month	to the cause(s)
F \$ F 0		30. Name and ad	NUL 950 dress of person who c	Completed cause	200	n 23a) (Type, I	Print)				EMBER 3,	
	tate	Pa	mela E-5 nth. Day, Year) DEC 07 21	Southa	gistrar's Signa	<b>D</b>	111 P	ENN STRE	EET, BALT	IMOR	RE, MARY	LAND, 21201

			1 - State of Maryland / De State of Maryland / De Company	partment of Hea ertificate of De			ene g. No. 0 14	38647	
	Physici		Decedent's Name (First, Middle, Last)     GLADYS	LEVIN		2. Date of Death Month DECEMBER		3. Time of Death 6:40 P M	
	/Medic Examin	7.	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc			4c. County of Death		
	*·		JOSEPH RICHEY HOSPICE  5. Social Security Number  6. Sex  7. Age (In yrs. last birtha		ALTIMORE Under 24 Hrs.	8. Date of Birth	9 Ric	N/A	
L	Funeral Director		213-48-9660 1 N 2 X F 98 Yrs	Months Days H	Hours Min.	JUN. 19, 1	. 906 3. 500	thplace (State or Foreign buntry) WI	
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location				10d. Inside City Limits	
	e Mary ta-fah Liffed	ctor	MD N/A BALT	IMORE				1 X Yes 2 □ No	
	with th a or 28	Director	10. Street and Number	10f. Zip Code	1210	109	g. Citizen of What Co	ountry? USA	
	death	Funeral	1190 W. NORTHERN PARKWAY #211  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispa If Yes, specify Cuban, M		ecify Yes or No-	14. Race - Ame	erican Indian,	
36	filed within 72 hours after death with the Maryland Hygiene. Idher than "natural", or terms 23a or 28a-1 ahow ont, the Medical Examera must be rediffied at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 M No If Yes, Give 3 M Widowed 4 ☐ Divorced Year or Dates:		Specify:	riidan, dic.)	Black, White	WHITE	
5-0036	72 hou natura	sted t	15. Decedent's Education 16a. De	ecedent's Usual Occupation	in most of worki	na 16	6b. Kind of Business	/Industry	
121	within ene. than "	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	ng moot or work	9	DIETARY		
nd 2	be filed ntal Hygi od other event, t	Be Cc	17. Father's Name (First, Middle, Last)		3. Mother's Name	(First, Middle, Ma	aiden Sumame)	<u> </u>	
Maryland	should b nd Menta n marked umatic e	10	JOSEPH  19a. Informant's Name/Relationship (Type, Print)  19b. M	SCH ailing Address (Street and	STELLA	J. Down March and J.		INTER	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or items 23a or 28a-f ahow mith jnjury or other traumatic event, the Medical Evaprime must be notified at once.			D2 BRYNMOR CO					
more,	Pages 1 and of Hernary or other		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	sposition (Name of crematory or other place)			0c. Location - City or		
Baltim	permit. Page Department Important: If any injury o	1	'4 ☐Donation 5 ☐Other (Specify) BALTIMOR	RE HEBREW CEN  22. Name and Address of			REISTERSTO ON & BROS.	•	
ä	Dep Imp	4	Milliall Druger	8900 REISTER				•	
<b>R</b> 1			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only on cause on each line.  Immediate Cause (Final	enter the mode of dying, so	such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death	
	Pnysician /Medical	d. IV	disease or condition resulting in death)  Due to (or as a consequence of):	mi of the	breast	c page	siba		
	Examiner		Sequentially list conditions b. puriosities	is to be	eam			1 y,	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					70	
50,	ficate be executed physician and s the burial-transit	al Exa	resulting in death) Last Due to (or as a consequence of):						
09/89	ificate t g physical as the b	edical	d.						
Вох	The law requires that the death certificate has been signed by the attending ragge 2 should be detached for use as	by Physician/Me		3 ☐Ectopic pregnancy			23d. Date of del	ivery Day Year	
o.	the dea by the a	nysic	1 ☐ Yes 2 D No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)	· · · · · · · · ·			Day Tour	
S, D	es that igned b	by Pi	Part II. Dther significant conditions contributing to death but not resulting in the	a underlying cause given in	n Part I.		acco use contribute to		
Records,	w requir been si should	eted	Hunes Tension	years m_1		1 Yes		obably 4 Unknown	
	The lav	Completed	(VA = realton Suboreak int.	nets pour	net's	autopsy performe	prior to death?	completion of cause of	
Vita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Other		(Check only one)	)		
	ding Phys h. After this c tuneral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at		me 5 Residen 28d. Describe how	ice 6100ther (Spe vinjury occurred	city) HOSPICE	
Division of	I or Attending Ph after death. Director: After thi I in by the funeral	catio	2 Accident investigation	M 1 TYes	: 2 □No				
$\overline{\Delta}$	al or At after of Direct	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office		City or Town,	eet and Number or Ru State)	irai Houte Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical (	29a Certifier  (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, d 2 ☐ Medical Examiner: On the basis of examination and/o	eath occurred at the time, or investigation, in my opinion	date and place, a on, death occurr	and due to the cau ed at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License nu	-		d. Date signed (Mont		
	11		30. Name and address of person who completed cause of death (Item 23a) (Ty	DO22	67V		2/3/04		
-	10		Michaus G. HAYES, MD 827	Linden Are	, B	altrino	re, Mcl.	21201	
	Sta Registi		31. Date filed (Month, Pay, Year)  32. Registrar's Signature	DOZZ De, Print) Linden Ave Sporks	,				

			1 - For State of Maryland / Department / Department / Department / Department / Department / Dep	rtment of Health and Me tificate of Death	ntal Hygier	1004 00040
ı	Physicia	an	Decedent's Name (First, Middle, Last)  DAVID ALLAN MAL	TON	. Date of Death Month	3. Time of Death 7:58A M
	/Medic			4b. City, Town, or Location of Death		Ic. County of Death
	Examin	er	7916 Seabreeze Dr.	Baltimore		nne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		214 66 2508 12M 2 F 51 Yrs.		11 19 19	953 Maryland
	pu 🛊		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	sho	ō	MD Anne Arundel Baltimore			1 ☐ Yes 2 X No
	28e-i	Director	10e. Street and Number	10f. Zip Code	100.0	Citizen of What Country?
	with 3e or		7916 Seabreeze Dr.	21226	109.0	U.S.A.
	death ms 2;	Funeral		as Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ri	y Yes or No-	14. Race - American Indian,
9	after or ite	필	1 Never Married 2 Married 1 Yes 2 No 19/4-	Yes, specify Cuban, Mexican, Puerto Hii □ Yes 2 <b>⊠</b> No <i>Specify:</i>	can, etc.)	Black, White, etc.
ဗ္ဗ	within 72 hours after death with the Maryland ene. Then "netural" or liems 23e or 28e-f show he Movical Exercities mant be notified at	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates: 1975	Tes Zanino Specify.		Specify: White
Ž	72 h "netu	Completed	(Specify only highest grade completed) (Give k.	ent's Usual Occupation and of work done during most of working	16b.	Kind of Business/Industry
12	within	dw	Elementary/Secondary (0-12) College (1-4or 5+)	ONOTuse retired)  C Driver	5	istribution
N D	Hygie Hygie ther i		17. Father's Name (First, Middle, Last)	18. Mother's Name (I		
an	d be ental ked o	To Be	Earl V. Mallon, S	Sr. Anna I	J. Tate	
Maryland 21215-0036	shound Mind Mind Mind	-		Address (Street and Number or Rural F		or Town, State, Zip Code)
Š	alth ar		Victoria Mallon - sister 7916	Seabreeze Dr.	Baltimo	ore, MD 21226
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healin and Mental Hygiene.  If it is marked to ther then "netural", or Items 23e or 28e-f show it it marked to ther then "netural", or Items 27 is marked to the Then "netural" or other treumetic event. It is Modical Exercited mast be notified at		20a. Method of Disposition Entombment  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, cremation	ition (Name of Dat atory or other place)	e 20c.	Location - City or Town, State
<u>E</u>	Pages nent of I ant: If its ury or o		'4 Donation 5 Chocity) Cedar Hi	11 Cem 12-7-	2004 Ba	ltimore, MD
Baltimore,	permit. Pages Department of Importent: If i any injury or o		1.	Name and Address of Facility G.J 169 Riviera Dr.		Funeral Home, PA ena, MD 21122
	THE REAL PROPERTY.		23a. Part1. Enter the disease or complications that caused the death. Do not enter shock, or heart failure. List only one cause are each line.			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		4thm.	Onset and Death
	/Medical		resulting in death)  a.  The jo (or as a consequence of):	ance juice	1	
	Examiner		Sequentially list conditions b. Hyteriocher	otic Heart	D15+	ASR
	sit ad	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	and and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
8760,	cate be executed by sician and the burial-transit	alE	Sub-ta-(til dis di sonisciquariles er).			
687	phys phys s the	edical	d			
Box (	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	E I SUITE CALLED		23d. Date of delivery
ă	death e atte d for	icia	in the past 12 months?  1 Vec 2 No. 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
O.	that the de led by the a detached f	hys	9 Unknown			
o. S	w requires that been signed be should be det	by Р	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		use contribute to the cause of death?
ord	equiri en si ould b	ted	Depression		1 🗆 Yes	2 No 3 Probably 4 Unknown
ecc	law r as be 2 sh	ple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The ate h page	Completed by			performed? 1 ☐ Yes 2 🛣	death? lo 1 ☐ Yes 2 ☐ No
/ita	Physician: r this certificanal director,	Be	25. Was case referred to medical examiner?	26. Place of Death (6	Check only one)	
of o	Physic this o	7	1 Ves 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of			6 ☐Other (Specify)
nc.	ding F h. After funer	lon	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at 28e Work?  M 1 ☐ Yes 2 ☐ No	d. Describe how in	ury occurred
isi	l or Attendi after death. Director: A in by the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined		Location (Street a	and Number or Rural Route Number,
Division of Vital Records,	after Dire	Certification;	4 Homicide determined building, etc. (Specify)	0, 1400, 01100	City or Town, Sta	re)
	To the Hospitel or Attending Physicien: The law within 24 buous after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death (Check only Medical Examiner: On the basis of examination and/or inve	occurred at the time, date and place, and	due to the cause	s) and manner as stated.
	To the H within 24 To the Fi complete	ledical	one) and manner stated.			
	To with	Σ	29b. Signature and title of certifier	29c. License number 06.0574		Pate signed (Month, Day, Year)
	11		William 1 1 mo	0000		12/6/4 A 20035
	01.		30. Name and address of person who completed cause of death (Item 23a) (Type, P	(1095 / FT	NRICIT.	A 20035
	Sta	te.	31. Date filed (Month, Day, Year) 32 Registrar's Signature	015 10	7	
	Registr	•	DEC 0 7 2004	The same of the sa		

State of Maryland / Department of Health and Mental Hygier 0 1 38649 1 - For Stata Ragistrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mary Rita McHugh December 4, 2004 5:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Baltimore Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 ☐ M 2 🖫 F 71 Yrs. Director 215-30-0529 Maryland 8. Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show 1 ☐ Yes 2 No Director Baltimore Maruland Parkville. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumatic event, I've Mudical Examiner to 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry 1.2 should be filed within 7.5 h and Mental Hygiene. 7 is marked other than "n. Motor Vehicle Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Chief Processor-Titles & Liens Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John M. McHugh Mary Busick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ? 1 ? 34 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m any injury or other traum once. Mrs. Eleanor McHugh (sister-in-law) 8800 Walther Blvd, Apt. 2004, Parkville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signal of I neral + rvic 10 nsee 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemeżeru 12/8/2004 Baltimore. Maruland 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Vasu las Demen /Medical Due to (or as a consequence of): Examiner cerebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a sunsequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed · hete Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IE EEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown Ity drocephalus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 versing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 10 Certification: To Director: After this in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) monic 1758641 M.O December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walther Boul- 00 Anna monias 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 0 4 1 - For State Registrar 38650 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 1817 M Emma Noelle Moss 02 )ecember 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Little Year If Under 24 Hrs. Min. Johns Hopkins pital 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** Days 4 1□ M 2 F N/A Director Usuat Residence of Decedent the Maryland 10a State 10b Counts 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 234 Old Line Avenue or Items 23a 20724 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Raymond Moss ပ Melissa Sloan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If item 27 Is any njury or other trauguts. William Moss/Father 234 Old Line Avenue, Laurel, MD 20724 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State \* 4 Donation 5 Dother (Specify) West Arundel Crem. 12/7/2004 ODenton, MD 21. Signatur of Funeral Servic Licen 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD M00773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** congenita /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I the detached 9 Unknown 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has le 2 autopsy perform micro ophtha Imio 2K No 1 Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death Check only one) examiner? 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide filled in Tycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 December 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOON WOLFE ST BUTO, MOZIZSF Johns Hopkins Hospital 31. Date filed (Month Pay 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 38651 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death DECEMBER Day **Physician** 2004 Joyce Maley 4:45 P /Medical 4a. Facility Name (If not institution, give street and number)
FRANKLIN SQUARE HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner ROSEDALE BALTIMORE CO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 200 216-58-1817 40 Yrs. Director 7-10-1964 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is markad other then "naturel", or Items 23e or 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23e or 28a-f show Examiner must be notified at MD Baltimore Raspeburg 1 ☐ Yes 2 XNo Completed by Funeral Director 10e. Street and Number 4504 Springwood Avenue 10g. Citizen of What Country? 10f. Zip Code 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 7 is marked other then "naturel", traumatic event, the Medical Ex 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Pastore's Italian (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Deli Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Habicht Joyce Μ. (Rodrick) ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Douglas Maley (Husband) 4504 Springwood Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Importent: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State First United Evan. Ch. Cem. 12-7-2004 <sup>4</sup> □Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licensee 1211 Chesaco Ave Rosedale, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Curdioviscular **Physician** Hypertensive disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the Ś signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 □ No page 1X Yes 2 🗆 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 Ĭ DOA SIL 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) DECEMBER 3, 2004 29b. Signature and title of certifier 29c dicense Mumbe 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) 111 PENN STREET, BALTIMORE, MARYLAND, 21201

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 7 2004

			For State Registrar	State of M	Marylan	d / Depa	artment of	Health	and Me	ental Hyg	ien <b>2</b> () (	) 4	38652
	Physici	an	1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month		Year	3. Time of Death
	/Medic	al	Corrine D.		1		4h City Town		a of Dooth	11/27	7/2004	of Dooth	7:20AM <sup>M</sup> .
	Examin	er	4a. Facility Name (If not institution, 3103 Belmont		91)		4b. City, Town				4c. County	or Death / A	
	Funeral			3. Sex 7	Age (In yrs. I	ast birthday)	If Under 1 Ye  Months Day		er 24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign
	Director		238-62-1887	1□M 2x□F	76	Yrs.	Months	ys Hours	IVIII I.	Sep 13,			
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					T	10d. Inside City Limits
	Many m-1 eh	tor	Maryland	N/A				Baltimor	е				1 Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Cod			1.	0g. Citizen of V		,
	eath v	erai	3103 Belmont	12. Was Decede	nt Ever in III	S 12 1	Was Decedent	212		ifu Voc or No.	14 Race	U.S.A	can Indian,
က	or Item	Fun	1 Never Married 2 Marrie	Armed Force	s?		Was Decedent of f Yes, specify C			ican, etc.)		k, White,	
003	urel', c	d by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Date:	s:		1 ☐ Yes 2 🕱 1	No Specif	y:		Specify		Black
<u>1</u>	n 72 t	iete	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual Oc <i>kind of work d</i> o DO NOT use rei	ne durina ma	ost of working	g	16b. Kind of Bu		,
212	d with giene. ir ther	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)			me Mak	er			Hon	ne
p	be filed within 72 hours after death with the Maryland ital Hygiene id other then "naturel", or Iteme 23a or 28a-1 ehow event, I've Medical Exam Ferminer must be notified at	Be	17. Father's Name (First, Middle, La					18. Mot	her's Name	(First, Middle, M			
Baltimore, Maryland 21215-0036	hould d Men marke matic	P	±ug 19a. Informant's Name/Relationshi	ene Bell		10h Mailie	ng Address (Stre	not and Num	har as Ousal		h Chance		Code
S	nd 2 s lith an 27 le r r trau		Romona	McCov			103 Belmor					31a10, ZI	Code)
ore,	ss 1 al of Hea item r othe		20a. Method of Disposition		00	lace of Dispo	sition (Name of natory or other)	olace)	Da	te	20c. Location -	City or To	own, State
<u>E</u>	Page ment ent: If		1 🔀 Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe			rrison Fo	rest Vetera	ns Ceme	etery 1	2/06/04	Owings	Mills ,	Maryland
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Indepartment of Health and Mental Hygiene. Importent: If item 27 Ie marked other then "naturel", or Iteme 23a or 28a-1 ehow amportent: If item 27 Ie marked other then "naturel", or other traumatic event, I'm Medical Exam far must be rollified at once.		21. Signature of Funeral Service Li	GH.		22	Name and Ad. Estep 1300			I Home P.A timore, MD	A. ) 21217		
			23a. Part1. Enter the disease, or or shock, or heart failure. List or	inplications that caus nly one cause on each	ed the death		er the mode of o	tying, such a	is cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a SPA	HIN		MUN						6 min m
	Examiner			Due to (or a	as a consequ	ience of):							
15	D =	ner	Sequentially list conditions, if any, leading to immediate	b Due to (or a	as a consequ	ience of):							
A.F	and errans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	ionoo of):							
. Box 68760, △	cate be executed oblysician and the burial-transit	dicai E		200 10 (0)	23 2 00113640	iorico or).							
687	tificate ig phy: as the	ledic		0.									
30X	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth		death 3	Ectopic pregna				23d. Date Mor		ery Day Year
o.	he dea	ysici	1 Yes 2 No 9 Unknown	4□Pregnant 9□Unknown		eath 5	Other (specify)				14101		Day Teat
s, G	The law requires that the ate has been signed by th page 2 should be detache	by Ph	Part II. Other significant condition	s contributing to death	n but not resu	ilting in the u	nderlying cause	given in Pari	tl.	23e. Did tob	acco use contr	bute to the	ne cause of death?
ords	w require been sig should b									1 ☐ Ye	s 2000	3 🗌 Prob	pably 4 ∐Unknown
Vital Record	e law re has be je 2 sho	Completed								24a. Was an	у р	rior to co	psy findings available mpletion of cause of
E E	r: The		LO LL TRANSPORT TO A TOTAL								12 No 1	eath?  Yes	2 No
₹	s certification	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	atient 2 1	ER/Outpatien	t 3 DOA	Other		Check only one 5  Reside		r (Specif	iv)
Division of	Attending Physician: or death. ector: After this certifice by the funeral director, I		27. Manner of Death 1 ■Natural 5 ■ Pending	28a. Date of Ir		28b. Time of	28c. lr	njury at		d. Describe ho		, ,	,,
Siol	uttendir death. ctor: Al y the fu	catic	2 Accident investiga 3 Suicide 6 Could no	t he				Yes 2					
<u>&gt;</u>	l or At after o Direc I in by	Certification:	4 Homicide determin	ed 286. Place of	etc. (Specify	me, farm, str	eet, factory, offic	00	28	City or Town		r or Hura	il Route Number,
_	e Hospital 24 hours a e Funerel I letely filled		29a. Certifier 1 Certifying	Physician: To the be	st of my know	wledge, death	occurred at the	time, date a	and place, an	id due to the ca	use(s) and mar	ner as s	tated.
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Aedical	one)	caminer: On the basis and manner	or examinat stated.	ion and/or in							
	To To con	Σ	29b. Signature and title of certifier	0. 10				anse number		29	12/3/0		υay, Υear)
			30. Name and address of person w	no completed cause o		23a) (Tvne		1260			1215/0		
	3		Bally Melsenbe					130	Himse	, MD	2/20	1	
	Sta		31. Date filed (Month, Day, Year)	6	strar's Signat	ure	1			_			
	Registr	ar	DEC 0 7 20	34 Signe	- Marilland	23	book	/					

DHMH 17 Rev 1/2001

ORIGINAL

			1- For State of Maryland /	Department of Health and Mental Certificate of Death	Hygiene 04	38653
	Physici /Medic		Decedent's Name (First, Middle, Last)     James Alva Mise	Monti	of Death h Day Year こといBER 63 )	Man man is a
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  NORTH ARUNDEL HOSPIT  5. Social Security Number  6. Sex  7. Age (In yrs. last bit)  219-38-8325  Usual Residence of Decedent	introduct If Under 1 Year If Under 24 Hrs. 18 Date		ARUNDEL irithplace (State or Foreign VA
	Maryland -f show iled at	tor		wn or Location Glen Burnie		10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	h with the	al Director	10e. Street and Number 807 Bunch Avenue	10f. Zip Code 21060	10g. Citizen of What C	Country?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "natural", or Itams 23a or 28e-f show aumatic event, the Maryleal Exercitation intellight and	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ▼ Yes 2 □ No 1959-  1 ↑ Yes, Give Year or Dates: 1963	13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc)  1 Yes 2 No Specify:	or No- Black, Wh Specify:	nerican Indian, nite, etc. White
9500-6121	within 72 ho ene. than "natur the wedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stationary Engineer	16b. Kind of Busines:	
Maryland 2	be be	To Be Co	17. Father's Name (First, Middle, Last) Timothy Mise	18. Mother's Name (First, M Ola Hester		
	is 1 and 2 should of Health and Meritam 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  Vincent Mise / son	b. Mailing Address (Street and Number or Rural Route N 803 Bunch Avenue, Glen B	•	
Baltimore,	90-		Burial 2 Cremation 3 Removal from State	of Disposition (Name of env. crematory or other place)  Haven Mem. Park 12/07/200	20c. Location - City o	
Baltı	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  Mo135	22. Name and Address of Facility Sing1	eton Funeral	Home, P.A.
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence	not enter the mode of dying, such as cardiac or respirate		Approximate Interval Between Onset and Death  Geors
	Examiner particular pa	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	of):		
68/60,	iicate be executed physician and s the burial-transit	dical	resulting in death) Last  Due to (or as a consequence d.	of):		
O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of de Month	elivery Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting  Pr. many hypothy rold dis		Did tobacco use contribute to	to the cause of death?  Probably 4 Unknown
A Kecords,	The law ate has b page 2 sl	Completed	Adrenal insufaccion		autopsy prior to death?	autopsy findings available completion of cause of s 25040
T VITA	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2  Hospital: 1  Inpatient 2  ER/O	26. Place of Death (Check of Dutpatient 3 DOA Other: 4 Nursing Home 5	only one) Residence 6 □Other (Spe	ecify)
lon of	nding Ph th. :: After th e funeral			Time of Injury at Work?  M 1 □ Yes 2 □ No	ribe how injury occurred	
DIVISION	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune.	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury · At home, for building, etc. (Specify)		ion (Street and Number or R or Town, State)	Rural Route Number,
	ta Hospit 24 hour ta Funari	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.	ie, death occurred at the time, date and place, and due to nd/or investigation, in my opinion, death occurred at the t	the cause(s) and manner a time, date and place, and du	as stated. ue to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier  Las 5 Lucy W	29c. License number  D 24285	29d. Date signed (Mon	hith, Day, Year)
	Q		30. Name and address of person who completed cause of death (Item 23a)  Charles & Wilos The North	(Type, Print) Hospital	301 Hosp	ital Or
Ţ	Sta		31. Date filed (Month, Day, Year) 7 2004 32. Registyr's Signature	& Sparks	- CHEN ISE	)

	Amend item/28f, per 0 388 12/7/04 TT Department of Maryland Department State of Maryland Cell Registrar	artment of Health and Mental Hygiens	HILL AND TH
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  Julius J. Madolny  4a. Facility Name (If not institution, give street and number)		Year 3. Time of Death 730 P M
Funeral Director	7601 Merritt Point Road  5. Social Security Number 215-24-4175  6. Sex 1XD M 2D F 75  75  Yrs.	Baltimore Mel 760 (Mel Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 3,19	9. Birthplace (State or Foreign Country) Maryland
Maryland fined at	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  Maryland Baltimore	Dundalk	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
virbin 72 hours after death with the Maryland ene. Then "natural", or Items 23a or 28a-f show he Madical Examitrational by modified at ompleted by Funeral Director		100	ited States  14. Race - American Indian, Black, White, etc.
21215-0036 ed within 72 hours after giginal, natural, or later than "natural, or later than "natural;	3(2) Widowed 4 □ Divorced Year or Dates: 1950-52  15. Decedent's Education   16a. Decedent's Concilio only highest grade completed)   16a. Decedent's Concilio only highest grade completed   16a. Decedent grade completed grade completed grade completed grade completed grade gra	1 ☐ Yes 2 ☑ No Specify:  dent's Usual Occupation kind of work done during most of working DO NOT use retired)  DO NOT use retired)	Specify: White
N = = = 0	Elementary/Secondary (0·12) College (1·4or 5+)  12 Years  17. Father's Name (First, Middle, Last)	·	
	Mrs. Linda M. Linz / Daughter 2309	ng Address (Street and Number or Rural Route Number, City of Queensbury Drive Fallston	or Town, State, Zip Code)
Baltimore, permit. Pages 1 at Department of Heal Important: If them any injury or othe pare.	'4 □ Donation 5 □ Other (Specify) Bel Air I	matory`or other place)	Air, Maryland
Frysician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	1922 Wise Ave. Dundalk, Majer the mode of dying, such as cardiac or respiratory arrest, a fulficility of the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, and the mode of dying, and the mode of dying, and the mode of dying arrest a	Approximate Interval Between Onset and Death Grass Sover Sylves S
Fius N. Box 68 death certifica e attending phid for use as the control of the con		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
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ding After fune	25. Was case referred to medical examiner?  1	f 28c. Injury at Work? M 1 Tyes 2 No	ry occurred  and Number or Rural Route Number,
Hospita 24 hours 5 Funeral ately filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deatt 2 Medicel Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to the cause(s) vestigation, in my opinion, death occurred at the time, date and	) and manner as stated. d place, and due to the cause(s)
To the within To the comple	30. Name and address of person who completed cause of death (Item 23a) (Type.	). DOOD-383 11	te signed (Month, Day, Year)
State Registrar	31. Date filed (Magin Pay, Year)  DEC 07 2004  32. Registrar's Signature	Sport Sport	wel Md 21214

			1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of He rtificate of D	ealth and M Death	lental Hygie		38655		
	Physicia		1. Decedent's Name (First, Middle, Last) $BETTY \\$	J. NEAL				2. Date of Death Month December	Day Yea 06, 200	3. Time of Death 4 6:30 a M		
	/Medic Examin		4a. Facility Name (If not institution, give st 600 Light Street	,		I	altimore		4c. County of De	eath		
	Funeral Director		5. Social Security Number 6. Sex 217−38−2285 1□  Usual Residence of Decedent	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye) Jan. 28, 19	ear)	Birthplace (State or Foreign Country) [aryland		
	e Maryland ta-f show lifted at	ctor	10a. State 10b. County Maryland N/A	10c. City	, To <b>wn</b> or Lo B	cation altimore			10d. Inside City 1X□Yes			
	th with th 23s or 26 Ist be no	al Director	10e. Street and Number 600 Li	ght St.,		10f. Zip Code	21230	1	Citizen <i>o</i> f What ISA	Country?		
980	urs after deat al', or items : Eva Tilrer mu	by Funeral	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 反 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1	i	Was Decedent of His if Yes, specify Cuban 1 ☐ Yes 2 🗓 No		ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	mencan Indian, hite, etc. White		
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or items 23a or 28a-f show ent, the Madical Evantiner must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) Attend:	ring most of work	ing	nights I	ss/Industry Laundromat		
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Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-1 show eny injury or other treumetic event. Ite Madical Evantings must be rotified at once.		19a. Informant's Name/Relationship (Type Carol Rudy  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	(Daughter)	710 ace of Dispo	ng Address (Street an Griffith sition (Name of natory or other place) Crematory	Rd., Gle	en Burnie.	Md.	21061		
Balti	permit. Departm Importe eny inju		27 Signature of Funeral Solvice Licensed		er   22 M	Name and Address IcCully-Po 30 East F	of Facility lyniak Fort Ave.	uneral Ho . Baltimo	me, P.A.	21230		
	Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of the fair.	Due to (or as a consequence to (or as a consequence)	Do not ent	er the mode of dying,	such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death LYEAR		
8760,	death certificate be executed e attending physician and of for use as the buriat-transit		that initiated events c. resulting in death) Last d.									
.O. Box 6	that the death certific led by the attending p detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year		
S, D	w requires that been signed b should be deta	by	Part II. Other significant conditions cont		-	, ,		23e. Did tobacc		to the cause of death?  Probably 4 □Unknown		
Vital Record	The lay	Completed	severe ch	MONARY	Di	sease		24a. Was an autopsy performed	prior to death	autopsy findings available o completion of cause of ? as 2 12 No		
of	Attending Physicien: rr death. ector: After this certific by the funeral director.	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigation		ER/Outpatien 28b. Time of Injury	t 3 DOA Other 28c. Injury a Work?	4 Nursing Hot	n (Check only one) me 5 2 Residence 28d. Describe how in		pecify)		
Division	a Hospitel or Atten 24 hours after deatl 5 Funerel Director: etely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (Street City or Town, St		Rural Route Number,		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physi 2 Medical Examine 29b. Signature and title of certifier	cian: To the best of my know er: On the basis of examination and manner stated.	vledge, death on and/or inv	occurred at the time vestigation, in my opin	nion, death occurr	ed at the time, date	e(s) and manner and place, and di	ue to the cause(s)		
	M. M.	_	Durin X	Strain	西人	ri) Du				04 TMD 21202		
	1		FRANCIS X.	STRAIN	100	7 1 1 8	301 5	T PAUL	2 isac	* MD 21202		
	Sta Registr	-	DEC 0 7 2004	32. Registrar's Signatu	6	Sparks!						

For State Registrar	State of Maryland / Department of Health and Certificate of Death		38656
1. Decedent's Name (First, Middle, Last	)	2. Date of Death	3. Time of Death
Donald Francis	Ohl	December 5, 2004	7:40 P

**Physician** /Medical Examiner

4a. Facility Name (If not institution, give street and number)

4121 Glen Park Road 5. Social Security Number **Funeral** 

1-

7. Age (In yrs. last birthday)

4b. City, Town, or Location of Death Baltimore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

Baltimore Birthplace (State or Foreign Country)

4c. County of Death

29d. Date signed (Month, Day, Year)

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at each.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

ho-5-21

Sonald F. Ohl

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	210-24-4075	X	14	Yrs.			Se	pt. 4, i	1930 Ma	ryland		
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Locat	tion					10d. Inside City Limits		
ō	,	***	Too. City, Town							1 ☐ Yes 2 ☑ No		
ect	Maryland Baltim  10e. Street and Number	one	<u> </u>	bu	ltimore			40: 0	data and a data and a data			
ā					10f. Zip Code	0102/		10g. C	itizen of What C			
rai	4121 Glen Park R			1		21236			U.S.A.			
nue	11. Marital Status	12. Was Decedent Armed Forces?			es, specify Cu	ban, Mexica	rigin? (Specify ) an, Puerto Rican	res or No- I, etc.)	Black, Whi			
1 by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Xes 2 1 If Yes, Give Year or Dates:	Rorean Conflic	1 □	Yes 21XN	o Specify	<i>i</i> :		Specify:	White		
Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Deceden	nt's Usual Occ nd of work don NOT use reti	upation e during mos red)	st of working	16b.	Kind of Business	/Industry		
Com	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5	un un	ion 1	Repres	entati	ve	St	eel Indu	stry		
To Be (	17. Father's Name (First, Middle, Last) George Ohl						ner's Name <i>(Firs</i> IMCL	it, Middle, Maide ALLEN	n Sumame)			
	19a. Informant's Name/Relationship ( Mrs. Imogene Ohl	Тура, Print) (Wile)						ite Number, City	or Town, State, MD 2123			
	20a. Method of Disposition 1		20b. Place of cemeter				Date		ocation - City or			
	* 4 ☐ Donation 5 ☐ Other (Specifical Structure of the real Struct	212/	POURW		Cemete					Maryland		
	VALLETJA	A		97	05 Belo	iir Rd	., Balt	uner fui imore, l	neral Ho MD 2123			
	23a. P. 11. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.	the death. Do note.  hrowco	0				~	) (seise	Approximate Interval Between Onset and Death		
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):  a consequence of):									
mpieted by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		ctopic pregnan	су			23d. Date of de Month	livery Day Year		
ed by Pt	Part II. Other significant conditions of	ontributing to death be	_	the unde	erlying cause o	iven in Part	l. 2	3e. Did tobacco		the cause of death?		
Complet						<u>.</u>		4a. Was an autopsy performed? □ Yes 210 N	prior to	utopsy findings available completion of cause of		
Be	25. Was case referred to medical examiner?	Harrian					e of Death (Che	ock only one)				
<sup>o</sup>	1 ☐ Yes 2 No	Hospital: 1 Inpatie			3 DOA		-		6 □Other (Spe	city)		
atlon:	27. Manner of □eath  1 Natural 5 □ Pending  2 □ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. T	ime of njury		uryat ork? ]Yes 2. ☐		escribe how inju	ury occurred			
ertifica	3 Suicide 6 Could not be determined	9 00 Pt/1-1		rm, street	, factory, office	)	28f. Lc	ocation (Street a lity or Town, Stat	nd Number or Ri e)	ural Route Number,		
dical Certification: To	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best on niner: On the basis of and manner sta	examination and	, death od	ccurred at the tigation, in my	time, date ar opinion, dea	nd place, and du ath occurred at I	ue to the cause(s the time, date an	s) and manner as od place, and due	s stated. to the cause(s)		

State Registrar 29b. Signature and title of certifie

no completed cause of death (Item 23a) (Type, Print)

OFERALL, MELISSA] Baltimore. Maryland 21215-0036

				Type or Prir State of Ma								-	ble.	
			1 - For State Registrar		,		tificate of				Reg.	1 (3 (	4	38657
		\$	Decedent's Name (First, Middle, Last	)				***************************************		2. Date of D	eath			3. Time of Death
	Physic /Medi		MELISSA	OFER	RALL					Month	0	-29	Year O L	5:15PM
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of	Death		4	c. County		
17			GOOD SAMARIT		SSPI	TAC	BAL	71 M	01	RE		N/A		
	Funeral Director		5. Social Security Number 6. Se 439473194  Usual Residence of Decedent	X 7. Age	e (In yrs. last bir 33	thday) Yrs.	Months Days		Hrs. Min.	8. Date of B (Month, D June 5,	1971	7	9. Birth	place (State or Foreig ntry) fornia
	viand ow		10a. State 10b. County		10c. City, Tow	n or Loc	ation							10d. Inside City Limits
	the Marylan 28e-f show	to	Maryland N/A		Baltimor	e								1 X Yes 2 ☐ No
	th the	Funeral Director	10e. Street and Number				10f. Zip Code				10g. C	itîzen of W	/hat Cou	ntry?
	23e (23e (23e (23e (23e (23e (23e (23e (	aic	3203 Southern Avenue				21214					USA		
	tems	nue	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	as Decedent of Yes, specify Cu	Hispanic Origir ban, Mexican, I	n? (Spe Puerto f	cify Yes or N Rican, etc.)	0-		- Ameri k, White,	can Indian, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	10		☐ Yes 2X No						Whit	
Ş	72 hours after death with the Maryland neture!', or Items 23e or 28e-1 show dieal Examinat must be notified at		15. Decedent's Edu		16a.	Deced	ent's Usual Occi	upation			16b l	Kind of Bu		
21215-0036	within ane. then *	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give k	ind of work don O NOT use retir	e during most o	of workir	ng		wer Ca		Mustry
	filed Hygid other	Be C	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	· · · · ·	MING	CI	18. Mother's	s Name	(First, Middle				
Maryland	2 should be find and Mental His marked of reumetic ever	To B	Alcide Mann					Audrey	y Har	tjen				
lar)	2 should and Men is marke eumetic	ľ	19a. Informant's Name/Relationship (T)		19b		Address (Stree		or Rura	Route Numl	ber, City	or Town, S	State, Zip	Code)
	1 and 2 Health em 27 i		David O'Ferrall/Husba	nd			Southern	Avenue		imore M	aryla	nd 21	1214	
altimore,	Pages 1 nent of He int: If iten		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ F	Removal from State	cemeter	ry, crem	ition (Name of atory or other pl	· 1		ate	20c. L	ocation - (	City or To	own, State
Ë	tmen tent: jury		* 4 □Donation 5 □ Other (Specify)				rvice Cor		2/6/0		_	ison Ma	arylar	nd
Bal	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licens	⇔Christina	L. Hilton	1 22.	Name and Addi	Ruck, Ir		5305 Ha			1 044	24.4
- 1	40200		23a. Part1. Enter the disease, or comp	X. Null	the death Do					Baltimo		ryranc	212	
			shock, or heart failure. List only o	ne cause on each lin	10.			ing, such as ca	irdiac oi	respiratory	arrest,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a ANO			MIA	エN	2	) K 1	4			
	Examiner			Due to (or as	a consequence		KU-	ioni	r					
	Ä	Jer	Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying	Due to (or a	a consequence	of):	A-0 2				•		-	
	executed in and rial-transit	Examiner	Cause (Disease or injury that initiated events	PAR	ADO	Xi	CAL	EF	10	30 L	1			
o,		_	resulting in death) Last		consequence	/-				,	<u></u>			
9289	ate be hysici	ical		o VEN	1000		THE	om (	200	201	$\supset$			
39	The law requires that the death certificate be e. ate has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medicat	IF FEMALE:											
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal death		ctopic pregnan	су				23d. Date Mon		ery Day Year
P.0.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5∐	Other (specify)							
	res that the de igned by the a be detached t	h h	Part II. Other significant conditions co	ntributing to death bu	at not resulting in	the un	derlying cause g	iven in Part I.		23e. Did	tobacco	use contri	bute to th	ne cause of death?
ds	uires sign ld be	d by	STILLS	010	DEA	51	e i i			1 🗆	Yes 2	. □No	3 ☐ Prob	pably 4 Honknown
000	w require been si should I	Completed	PULMON	ARU	EM	B	010			24a. Was	2 20	24h W	lere auto	nev findinge available
Re	he ta e has age 2	шc	POFICIO	7			<u> </u>		_	auto	psy ormed?	pr	ior to co	psy findings available mpletion of cause of
ta	10	a	25. Was case referred to medical					26 Place of	f Death	1 Yes		11	Yes	2 No
of Vital Records,		To B	examiner?	lospital: 1 Ampatier	nt 2 ER/Ou	tpatient	3□ DOA O	han		e 5 ☐ Resi		6 ☐Othe	r (Specifi	y)
0	ding Ph		27. Manner of Death  1 Matural 5 Pending	28a. Date of Injur (Month, Day	y 28b. T	ime of	28c. Inju			8d. Describe				
Sio	endir sath. or: Al	atic	2 Accident investigation					]Yes 2□No						
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, fa. . (Specify)	rm, stre	et, factory, office		2	8f. Location ( City or To			r or Rura	I Route Number,
	urs a urs a erel D			-1-1										
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exemi	sicien: To the best on ner: On the basis of and manner sta	examination and	, death d/or inve	occurred at the testigation, in my	ime, date and p opinion, death	olace, ai occurre	nd due to the d at the time,	cause(s date an	) and man d place, ar	ner as si nd due to	tated. the cause(s)
	o the lithin o the omple	Mec	29b. Signature and title of certifier	वाज सवामाना ऽवि	A -		29c. Licen	se number			29d. Da	ite signed	(Month.	Day, Year)
	⊢s⊢ŏ		> V(lue) se	an N	1.	)	RI	551	00	00	0.00	0,0	3	200L
	it		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (	Type, P	rint) 560	V LO	CH	RA	VER	1 B	LVE	5
	"		VIRGINIE CH	HE BOU				TIMOR	,	M.		,—,		
	Sta		31. Date filed (Month, Day, Year) DEC 07 2004	32. Registra	r's Signature		books							
- 3	Registr	ar	DEC 0 ( 2004	Asset Barre	Per	1	y ours							

			1_ State	partment of Health and Nertificate of Death	Mental Hygie Reg.		38658
			1. Decedent's Name (First, Middle, Last)	- Dodin	2. Date of Death		3. Time of Death
п	Physici		Mary Vargo Oliv	er	November	Day Yeer 28 2004	11:45 A <sup>M</sup>
7	/Medic Examin		4e. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
		- 4	6117 Jerrys Drive	Columbia  If Under 1 Year   If Under 24 Hrs.	10 D-1 -1 D1-15	Howard	
٠	Funeral Director		5. Social Security Number 201-20-8936 6. Sex 1 $\square$ M 2X F 7. Age (In yrs. last birthdom) 1 $\square$ M 2X F 90 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sep. 29. I	914 Aus	hplace (State or Foreign untry) Stria
	pu ,		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or	Location			10d, Inside City Limits
	Aaryla   show	ь		len Burnie			1 ☐ Yes 2 ☐ No
	the h	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	th with		6664 Shelly Road Apt. 33B	21061		Austria	
	tams	Funerai		<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. vther than "neturel", or Items 23a or 28a-f ehow ent, the Madicel Exactiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1	1 ☐ Yes 2 🛣 No Specify:		Specify: wil	nite
Š	72 hou	ted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of work	kina 16b	. Kind of Business/	Industry
Maryland 21215-0036	nathin ne. han	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ales	9	Retail	
2	filed v Hygie ther t	CO	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid		
au	Mental Mental Mental Med o	To Be	Francis Vargo	Mary	Habershuk		
ary	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Madical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. M.	tiling Address (Street and Number or Ru	ral Route Number, Ci	ty or Town, State, 2	Zip Code)
e,	t and Health In 27 Ther tr			7 Jerry's Drive, Co		D 21044 Location - City or	Town State
ğ	Pages nent of I ant: If its		cemetery, c	rematory or other place) ven Mem. Park Dec	11/20	en Burnie	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is eny injury or other tra <u>once</u> .		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sin		neral Hor	ne P.A.
m	F S F S S		Muchalle Cooney MO1415	1 Second Avenue S.	W., Glen B	urnie, M	21061
R			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical			cancer			norths
	Examiner		Due to (or as a consequence of):				
2	n =	ner	Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury)				
	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE	d			1	
9	tificate ng phys as the	Medic	US SERVICE				
Box	attending p	Physician/Medical		3 □Ectopic pregnancy		23d. Date of del Month	very Day Year
o.	the deay	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			,
ر. ت	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
ğ	w require been sig should b	ted t	denentia		1 Yes	2 □ No 3 □ Pr	obably 4 □Unknown
Division of Vital Records,	law r has be e 2 sh	Completed			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
alH	iicien: The la certificate has rector, page 2				performed 1 ☐ Yes 2 ☐	No 1 Yes	2 No
Ξ.	Physicien: r this certificanal director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Out -	th <i>(Check only one)</i> ome 5 □ Residence	6XXOther (Sne	wdau hters
o c	ding Phys h. After this funeral di		27. Magner of Death 1 C Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury Injury (Month, Day Year)	of 28c. Injury at	28d. Describe how i		residence
sio	Attending ir death. ector: After by the fune	catic	Accident investigation	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	and Mumber - D	10-41
Σ	i Site	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S		rai noute Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled		29a. Certifier Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	, and due to the caus	e(s) and manner as	stated.
	the Hin 24 the Fi	Medical	one) and manner stated.	29c. License number		Date signed (Monti	
	T vit		29b. Signature and infe of certifier				
V	$\overline{}$		30. Name and address of person who completed cause of death (Item 23a) (Ty	<i>D 53636</i>		lov 29,	1004
_	1		KEVIN CARLSON MO 10700 charte	Prive Collentin	MO 21	044	
*	Sta Regist		31. Date filed (Month, Day, Year)  DEC 0 7 2004  32. Registrar's Signature	4 Sparks			
	riegist	e II	VEO 0 1 4004	- jagours!			

DHMH 17 Rev 1/2001

ROSLYN OSSEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 004 38660 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:45 P M December Mary D. Prymas 2004 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 3573 Elmora Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) MaryLand 8. Date of Birth (Month, Day, Yeer)
Dec. 28, 1925 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1 □ M 2 💢 F 78 Director 219-18-8679 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Modical Examinar next be notified at 1 Yes 2 No Directo Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? u. s. A. 21213 3573 Elmora Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Marned 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates þ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Heelth and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12th Grade Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sarajina Sgroi Guiseppe Brunetto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31 Ballast Lane, Stewartstown, Pennsylvania 17363 Donna Danner (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of the important: If ite eny Injury or of once. 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 12/6/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer months 9 **Physician** 1 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 2 No 1 Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical iCheck only 29d. Date signed (Month, Dey, Year) 29b. Signafüre and title of certifier 29c. License number December 043636 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodney Brooks Baltonore maryland 3120 Erlman 31. Date filed (Month DE)CYes 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

John Kevin Pugh 04-07675 C:

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		em 23a,27,28a	f per me Ce	rtificate of L	Priioritas Death			4 38661
sician	Decedent's Name (First, Middle		N DUCU			2. Date of Dea Month Novembe	-	3. Time of Death 3:09 P M
edical miner	4a. Facility Name (If not institution,	JOHN KEVI	N PUGI	4b. City, Town, or	Location of Death	<del></del>	4c. County	
mme	13201 Bermondse	-		Mitche	elville			e George's
eral		167M 2□ F	yrs. last birthday Yrs.	If Under 1 Year   Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	/, Year)	Birthplace (State or Foreign Country)
tor	578-84-4137 Usual Residence of Decedent	41				Jan 23	1963	Washington,DC
once.  To Be Completed by Funeral Director	10a. State 10b. County  MD Prince		c. City, Town or L					10d. Inside City Limits 1 GYes 2 □ No
Director	10e. Street and Number	George	Mitchell	10f. Zip Code			10g. Citizen of W	/hat Country?
alD	13201 Bermondse	y Court		20721			U.S.A.	
Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc.
d by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	ed 1 Tes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			White
lete	15. Decedent' (Specify only highes		(Give	dent's Usual Occupa kind of work done of	luring most of work	king	16b. Kind of Bu	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired,			Mozzina	
e Cc	17. Father's Name (First, Middle, L	_ast)	Full	Tture Mov	18. Mother's Nam	e (First, Middle,	Moving Maiden Surname	<del></del>
ToB	Lawrence Monroe	. Pugh			Rena Ila	a Hildre	th	
	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mail	ng Address (Street a	nd Number or Rui	ral Route Numbe	r, City or Town, S	State, Zip Code)
	Abigael Rael In						e, Mary	land 21224
	20a. Method of Disposition 1 X Burial 2 □ Cremation		Ob. Place of Disp cemetery, cre	osition (Name of matory or other place		Date	20c. Location - (	City or Town, State
	' 4 □ Donation 5 □ Other (Sp			Church C				, Maryland
ouce	21. Signature of Funeral Serve L	VII	0772 D	2. Name and Addres	Funeral I	Home & C	remator	y, P.A.
- 2	23a. Part1. Enter the disease, or	complications that caused the						yland 21113 Approximate
ian	Immediate Cause (Final	only one cause on each line.		,				Interval Between
al	disease or condition		カナハマコクタナ	rion				Onset and Death
	resulting in death)	Due to (or as a co	ntoxicat	ion				Onset and Death
		Due to (or as a co	nsequence of):	ion				Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):	ion				Onset and Death
ē 1	Sequentially list conditions.	Due to (or as a co	nsequence of):	ion				Onset and Death
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause these as a minury that initiated events	b. Due to (or as a co	nsequence of):	ion				Onset and Death
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (brease or injury that initiated events resulting in death) Last	b. Due to (or as a co	nsequence of):	ion				Onset and Death
cian/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause these as a minury that initiated events	b. Due to (or as a co	nsequence of):  nsequence of):  nsequence of):  regnancy  Fetal death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of delivery
cian/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause forbease or impury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	Due to (or as a co	nsequence of):  nsequence of):  regnancy Fetal death 3 is of death 5 is	□Ectopic pregnancy □ Other (specify)	n in Part I.	23e. Did to	Mon	of delivery
by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause Unesease or impuy that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a co	nsequence of):  nsequence of):  regnancy Fetal death 3 is of death 5 is	□Ectopic pregnancy □ Other (specify)	n in Part I.		Mon	of delivery th Day Year
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Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition	Due to (or as a co	nsequence of):  nsequence of):  regnancy Fetal death 3 is of death 5 is	□Ectopic pregnancy □ Other (specify)		1 🗆 Y  24a. Was a autop: perfor 1 Yes	bacco use contri	of delivery th Day Year  bute to the cause of death? 3 Probably 4 Unknown  fere autopsy findings available for to completion of cause of
o Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (processe or impuy that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition	Due to (or as a co	nsequence of):  nsequence of):  regnancy Fetal death 3 is of death 5 is	□Ectopic pregnancy □ Other (specify) underlying cause give	26. Place of Deat	1 🗆 Y  24a. Was a autop: perfor 1 Yes	Mon  bacco use contri es 2 \( \text{No} \)  in 24b. We say of the control of the	of delivery th Day Year  bute to the cause of death?  3 Probably 4 Unknown  fere autopsy findings available for to completion of cause of salt?  Yes 2 No
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iffication; To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lives as or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending	Due to (or as a co b. Due to (or as a co c. Due to (or as a co d.	nsequence of):  nsequence of):  regnancy Fetal death 3 is of death 5 is of death 6 is	□Ectopic pregnancy □ Other (specify) □ Inderlying cause give Int 3□ DOA If 28c. Injury Work	26. Place of Deat  C 4 □ Nursing Ho at ? es 2 ★ No	24a. Was a autop: perfor 1 Yes  th (Check only or ome 5  Resid 28d. Describe his city or Town	bacco use contriles 2 No 10 No	of delivery th Day Year  bute to the cause of death?  3 Probably 4 Unknown  for autopsy findings available for to completion of cause of path?  Yes 2 No  of (Specify) at scene  of unk  To a Rural Route Number,  Of Bermondsey
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iffication; To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dause Unsease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a co b. Due to (or as a co c. Due to (or as a co d.	nsequence of):  nsequence of):  nsequence of):  regnancy [Fetal death 3] of death 5[ of death 5]  at resulting in the terms of the sequence of):  2 EP/Outpatie 28b. Time of the sequence of):	DEctopic pregnancy Other (specify)  Inderlying cause give  at 3 DOA  At 28c. Injury Work  M 1 Y  reet, factory, office	26. Place of Deat  f. 4 □ Nursing Ho  at  f. es 2 ★ No	24a. Was a autop: perfor 14 Yes  h (Check only or ome 5 Resident 28d. Describe here)  28f. Location (S. City or Town  Mitchell  and due to the cored at the time, described to the cored to the cored at the cored at the cored at the cored at the co	bacco use contri es 2 No 3  an 24b. W pr med? 22 No 1  ance 6 Other ow injury occurre  treet and Number, State) 132( ville, I  ause(s) and man ate and place, ar	bute to the cause of death?  3 Probably 4 Unknown  for autopsy findings available for to completion of cause of bath?  Yes 2 No  (Specify) at scene  d unk  For Rural Route Number,  1 Bermondsey  (Aryland
edical Certification; To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dause Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a co b. Due to (or as a co c. Due to (or as a co d.	nsequence of):  nsequence of):  nsequence of):  regnancy [Fetal death 3] of death 5[ of death 5]  at resulting in the terms of the sequence of):  2 EP/Outpatie 28b. Time of the sequence of):	DOA Other (specify)  Int 3 DOA Other (specify)  Int 3 DOA Other (specify)  Other (specify)  Int 3 DOA Other (specify)  Pareet, factory, office  Int 3 DOA Other (specify)  Int 3 DOA Ot	26. Place of Deat  f. 4 □ Nursing Ho  at  f. es 2 ★ No	24a. Was a autop: perfor 14 Yes  h (Check only or ome 5 Resident 28d. Describe here)  28f. Location (S. City or Town  Mitchell  and due to the cred at the time, described here)	bacco use contri es 2 No  24b. W pr med? 22 No  220 No  250 No  24b. W pr de	bute to the cause of death?  By Probably 4 Munknown  There autopsy findings available for to completion of cause of eath?  There autopsy findings available for to completion of cause of eath?  There autopsy findings available for the completion of cause of eath?  There autopsy findings available for the cause of eath of ea

State Registrar

31. Date filed (Month, Day, Year)

DEC 0 7 2004

32. Registrar's Signature

Amend item/2/12, per R C338, 12/7/04 The State of Maryland / Department of Health and Mental Hygiene 1 1

38662 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4a. Facility Name (If not institution, give street and number) DECEMBER 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Manor Care - Rossville Rosedale 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6-19-1924 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 🌠 F 80 Yrs. Director 220-18-4381 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ith and Mental Hygiene. 27 Is marked other than "natural", or Items 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at Raspeburg MD Baltimore 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8 Glenmore Ave 21206 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Telephone Operator 0 Communication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fand Mental I Howard Chester Eva Virginia Charlton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If Item 27 Is any Injury or othar trau once. Samuel A. Culotta/Attorney 6305 Belair Rd, 1st. floor Balto MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cem. 12-6-2004 Baltimore \* 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Fundal Source Lichnsee 1211 Chesaco Ave Balto MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIA Physician /Medical Due to (or as a consequence of): DRYC Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown \$ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ DEMENTIA 1 ☐ Yes 2 ☐ No- 3 ☐ Probably 4 ☐ Unknown Completed been COLITIS 24b. Were autopsy findings available prior to completion of cause of death? HEMIC 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Tes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred il or Attending Fatter death. Division After Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital ovithin 24 hours at To the Funaral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Delle D55306 GH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 PHILADELPHA BD Surie Des BAGO ND 212 DENNIS H. ODIE 31. Date filed (Month Par. 32. Registrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

Registrar

2004

			1 - For State Registrar	State of	Marylan		artment <i>tificate</i>				Re	g. N20	04	386	
П	Physic		1. Decedent's Name (First, Middle, La Barbara J. Rawli	,							Date of Death Month <b>cember</b>	Day	Year	3. Time of	f Death P M
	/Medi Examir		4a. Facility Name (If not institution, giv		per)		4b. City, To		Location o	of Death	centrer	4c. Count	y of Death	8:15	F
	Funeral Director		232 00 7313		Age (In yrs. 65	la <i>st birthday)</i> Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. 8. ( Min. NO	Date of Birth Month, Day V. 8, 19	Year) 39	9. Birthi Coul Ohio	place (State ontry)	or Foreign
	show	'n	Usual Residence of Decedent  10a. State 10b. County  Manual and Delikims			y, Town or Lo				<del></del>	<u></u> - <u> </u>		1	l0d. Inside Ci	•
	r 28a-f	Director	Maryland Baltimo	re	M	iddle :	10f. Zip C	ode			10	g. Citizen of	What Cour		
	th with	al D	102 Dihedral Driv	е			2	122	0			USA			
980	s 1 and 2 should be filed within 72 hours efter death with the Maryland I Health and Mental Hygiene. I than "natural", or itama 23a or 28a-f show itam 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Medical Ever front marker rediffied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Date	es? ſ <b>Ž</b> (No		Vas Decede f Yes, specif I □ Yes 2		spanic Orig , Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- n, etc.)	Bla	ce - Americ ck, White, y: Whit	etc.	
Maryland 21215-0036	within 72 ho ene. then "netu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12		or 5+)	(Give life. L	lent's Usual kind of work DO NOT use ecreta	done du retired)	ırina most	t of working		6b. Kind of B		,	
d 2	filed withi Hygiene. other than		17. Father's Name (First, Middle, Last,				ecreta		18. Mothe	r's Name (Fir		Trash I aiden Suman		ar co.	
ylan	2 should be and Mental Is marked o	To Be	Clarence Wages							ıryn Da					
	nd 2 sh aith and 27 is m		19a. Informant's Name/Relationship ( Edgar Rawlings (							r or Rural Ro Baltimo				Code)	
Baltimore,	Pages 1 and 2 nent of Health int: If Itam 27 i		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		ate C	lace of Dispo emetery, cren	natory or oth	er place	1	Date		0c. Location	-		 Da
Balti	permit. Pages Department of I Important: If Itu any Injury or of		21. Signature of Financial Styles Light			22	. Name and Bruzdz	Address insl	of Facility	neral	Home F	. A.			IIG .
	Pnysician /Medical Examiner	16	21. Signature of Final Structure of Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear failure. List only one cause on each line.  Immediate Cayse (Final disease or condition resulting in eath)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								spiratory arres			Approximate Interval Bett Onset and D	ween Death
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rds, P	signed be de	þ	Part II. Other significant conditions of	ontributing to dea	th but not resu	ulting in the un	derlying cau	se giver	n in Part I.		23e. Did toba			e cause of de	
of Vital Records,	The law ete has b page 2 sl	Completed									24a. Was an autopsy performe	1	prior to con death?	osy findings a npletion of ca 2 No	
Vita	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ations OF	FD/0-1		Other		of Death Ch					
	ding h. After funel	$\vdash$	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of (Month,		ER/Outpatient 28b. Time of Injury		. Injury a	4 LJ IVUI		Describe how			")	
Division	i Diffe	Certification;	3 Suicide 6 Could not be determined	286. Place of	Injury - At ho , etc. (Specify	me, farm, stre	eet, factory, o	office		28f. L	ocation (Stre	et and Numb State)	er or Rura	Route Numb	oer,
	10 Th	edical C	29a. Certifier (Check only one) 1X Certifying Ph 2 Medical Exem	ysician: To the be niner: On the basi and manne	s of examinat	wledge, death ion and/or inv	occurred at estigation, in	the time my opii	, date and nion, death	d place, and d h occurred at	lue to the cau the time, dat	se(s) and ma e and place, a	inner as stand due to	ated. the cause(s)	
	To the P within 24 To the F complete	M	29b. Signature and title of certifier	. >				icense i			290	d. Date signed			
,	4		30 Name and address of	n	Street, Marie	22a) (T			.011				2.	2004	
	0		30. Name and address of prison who			23a) (Type, I	Brock	ANGG.	B	altimo	ne Mi	> 212	-31		
	Sta Registr	-	31. Date filed (Month, Day, Year) DEC 0 7 2004		istrar's Signat	ture!	pork		91	paltimo					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38665 State of Maryland / Department of Health and Mental Hygien [ ] [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 30 2004 Month (11) 1722 M **Physician** JOHN DAVID /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UNIVERSITY OF MARYLAND BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 28, 1975 Birthplace (State or Foreign Country) 6. Sex 1 XM 2 □ F **Funeral** <sup>7</sup>219<u>-84-0591</u> 29 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 ia marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be medified at 1 ☐ Yes 2 ☐ No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 806 Brunswick Road 21221 Apt.1A death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: White ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) N/A Disabled 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brenda J. Hendrichs Herman Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 la any injury or other trau once. 2140Redthorn Road Baltimore, Maryland 21221 Brenda J. Hendrichs/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State BayView Crematory 12/6/2004 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P.A. michael 1 6009 Hartord Road Baltimore, Maryland21214 23a. Part1. Enter the disease, or comuscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) aumatic rain **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown 9 🗌 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 1 Yes 2 No After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No ector, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral dire 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No Nov 29, 2004 1100 M 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide Street Rossville Blud and Franklin Sq t 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifié Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature AU4176435 A15752 Nov 30, 2004 dress of person who completed cause of death (Item 23a) (Type, Print) reene (+ RALTIMOIZE MD 21201 MARYLAND 0+ VERSITY )NY 31. Date fled (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/200 **ORIGINAL** 

		1 - For State Registrar	State of Ma	ırylanı	d / Depa <i>Cer</i>	rtment of F tificate of	lealth and N <i>Death</i>		giene Reg. No.	04 3	38666
Physici /Medic		Decedent's Name (First, Middle, Last)     AID	LA			RAIN		2. Date of De Month	Day	Year 2004	3. Time of Death
Examir		4a. Facility Name (If not institution, give st LEVINDALE HEBREW H	OME			BALTIMO				ounty of Death	N/A
Funeral Director		21, 02 0002	M 2 F 7. Age	82 (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month Da APR. 15	, 1922	9. Birth	place (State or Foreign ntry) POLAND
the Maryland 28a-f ahow	JO.	Usual Residence of Decedent  10a. State 10b. County  MD N/A		10c. City	, Town or Lo						10d. Inside City Limits 1 X Yes 2 ☐ No
ith with the h 23a or 28a- ust be routif	I Director	10e. Street and Number 2500 W. BELVEDERE		505	DALTI	10f. Zip Code	21215		10g. Citize	en of What Cou	ntry? USA
er dea	by Funeral		2. Was Decedent B Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates:	ver in U.		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White,	can Indian,
7.2 nd 21215-0036 e filed within 72 hours aft al Mygiene I other then "natural", or vent, tre Medical Exert	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 12	ation completed) College (1-4or 5	+)	16a. Deced (Give I life. L		during most of work		OWN	of Business/In	dustry
aryland should be file unaftic avant	To Be	17. Father's Name (First, Middle, Last) ABRAHAM		SZN	NAJDERN	1AN	18. Mother's Nam	e (First, Middle,	Maiden S	umame)	KANDEL
e, Mar. 1 and 2 she Health and am 27 is m.		19a. Informant's Name/Relationship (Typ SANTIAGO RAIN / H	•		2500	W. BELVE					Code) E, MD 21215
Baltimore, permit. Pages 1 ar Important: If item any injury or othan once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)  21. Sign fre Funeral Service Censor	moval from State	ī	3 SHAL(	Name and Addre	PARK  AL 12/0  ss of Facility SO  TERSTOWN	L LEVIN	REI SON &		WN, MD
Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused cause on each lin	the death	n. Do not ente		ng, such as cardiac			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequ	uence of):						
68760, ificate be executed g physician and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter undarphing Cause (Disease or injury that initiated events resulting in death) Last  d. d.	Due to (or as a								
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certifical tref death.  Director: After this certificate has been signed by the attending phin by the funeral director, page 2 should be detached for use as it in by the funeral director, page 2 should be detached for use as it.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,		230	d. Date of delive Month	ery Day Year
rds, P luires that n signed b	d by P	Part II. Other significant conditions cont	nbuting to death bu	it not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did to	/		ne cause of death?
al Record  The law requii	Completed	PVD idyporhypidemia	-					24a. Was autop perfo 1 \( \text{Yes} \)		24b. Were auto prior to co death? 1 \( \text{Yes}	psy findings available mpletion of cause of 2 \( \square\) No
on of Vital F ding Phyaician: Th h. After this certificate funeral director, pag	To Be	25. W case referred to medical examiner? 1 □ Yes 2 □ No Ho	ospital: 1		ER/Outpatient		492 (4013)119 110			Other (Specifi	y)
Division of Vital Records, all or Attending Physician: The law requires the after death. I Director: After this certificate has been signed in by the funeral director, page 2 should be din by the funeral director.	Certification;	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injur (Month, Day 28e. Place of Inju- building, etc	rv - At ho	28b. Time of Injury		y at k? Yes 2 □ No	28f. Location (S City or Tow	Street and I		l Route Number,
Divisi To the Hospital or Atten within 24 hours after deat To the Funaral Director: completely filled in by the		29a. Certifier 1 Certifying Physic (Check only 2 Medical Examina	cian: To the best of	of my know	wledge, death	occurred at the tin	ne, date and place,	and due to the	cause(s) ar	nd manner as si	lated.
To tha k within 2- To tha f	Medical	29b. Signature and title of certifier	and manner sta	ted.		29c. Licens	e number			signed (Month,	
6 h		30. Name and address of person who com 2434 W Bel	mo . npleted cause of de vielsne	eath (Item		Print) X/A Baltim	NGRONG		A0 2121	5	
Sta Registr		31. Date filed (Month, Day, Year) DEC 07 2	32. Registra	r's Signat	ture	Spor	h			_	

			1 - State Registrar	ite of Maryland	/ Dep <i>Ce</i>	artment of H <i>rtificate of L</i>	ealth and Death		gienje Reg. No.	004	38667
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		JOSEPH RE	ED				Month	2 1 Day	Zog 4	04024
	Examin	er	4a. Facility Name (If not institution, give street	,		4b. City, Town, or			4c.	County of Death	n
	Funeral	191	1 HERLY HOSPITA  5. Social Security Number 6. Sex		t birthdav	7, 0,	If Under 24 Hr		h	9 Rinth	polace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 12 M 2	□F 79	Yrs.	Months Days	Hours Mir	8. Date of Birt (Month, Da 10-16-	7, Year)	D.C	nplace (State or Foreign untry)
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or L	ocation					10d. Inside City Limits
	Maryla f sho	or	MD								Yes 2 No
	r 28a	rect	10e. Street and Number	Balt	_1 mo	10f. Zip Code			10g. Citi	zen of What Co	untry?
	th with	Funeral Director	1211 Gregor Way			21224			USA		
	er dea	nue	11. Marital Status 12. Wa	as Decedent Ever in U.S. med Forces? Yes 2 \( \) No	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		14. Race - Amer Black, White	
36	urs aft	by F	-V   If)	JYes 2∐No ∕es, Give ar or Dates:		1 ☐ Yes 2 🛣 No	Specify:			Specify.Whi	te
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at		15. Decedent's Education (Specify only highest grade comp	nleted)	6a. Dece	dent's Usual Occupa	ation	odeina	16b. Ki	nd of Business/l	industry
2	vithin ne.	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+)		kind of work done of DO NOT use retired,	)	orking			
7	Hygie Hygie ther t		6th  17. Father's Name (First, Middle, Last)	P	Plum	bing	18 Mother's Na	ame (First, Middle,	Sta		
an	ld be ental ked o	To Be	George A. Reed					. Golds		,	
ary	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type, Pr.	int)	19b. Maili	ng Address (Street a					lip Code)
	and 2 ealth a m 27 is	3	Karrie Harry		121	1 Gregor	Way B	alto. M	D.	21224	
ore	ges 1 it of H if ites or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Remova	20b. Place ceme	e of Dispo etery, cre	osition (Name of matory or other place	9)	Date	20c. Lo	cation - City or	Town, State
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 th any injury or other tra		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Euneral Service Licensee	Garr		n Forest	12-	-1-04	win	gs Mil	1, MD
Ba	Depa Impo any ir		Danoll L.	Genton	2	2. Name and Addres	We ern Δν	sley Ch	avi	s Jr.F	.H.
•,			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause	s that caused the death. I	Do not en	ter the mode of dying	g, such as cardia	ac or respiratory ar	rest,	UD 212	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		- B	Powel					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen-	ice of):						
	<u> </u>	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Descape of Figure	Due to (or as a consequen	ce of):						
	cuted bd ransit	Examiner	that initiated events							-	
90,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):						
68760	ficate t physics the b	edical	d								
Box				es, outcome of pregnancy					2	23d. Date of deli	very
	The law requires that the death cert lie has been signed by the attendin page 2 should be detached for use	Completed by Physician/M	in the past 12 months?	Live birth 2 Fetal dea Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)				Month	Day Year
<u>Р</u>	d by ti	Phy	9 ☐ Unknown  Part II. Other significant conditions contribution		a in the u	andoshina agusa siya	e in Don't	220 Did to	bassa u	aa aastributa ta	the cause of death?
Vital Records,	uires t	d by	Acute renal f	FILLE	ig iii iii <del>o</del> u	indenying cause give	iii ii Faiti.		es 2[		
S	w req	olete					-	24a. Was	an	24b. Were au	tonsy findings available
Re	Physician: The lav r this certificate has ral director, page 2	omo						autop perfor 1 Tes		prior to c death?	ompletion of cause of 2 No
/ita	cian: ertifica sctor, j	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only or			
	Physician: this certificatal director,	7	1 ☐ Yes 25 No Hospita  27. Manner of Death 28a	mpatient 2 EH/	Outpatier		4   Nursing	Home 5 Resid			sify)
Division of	or Attending Phater death. Director: After the in by the funeral	Certification:	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	at ? ′es 2∐No	28d. Describe h	ow injury	y occurred	
<u>                                      </u>	* Attendi	tifica	a Could not be	. Place of Injury - At home building, etc. (Specify)	, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and	d Number or Ru	ral Route Number,
ō	ital or A							II.			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier (Check only one)  Certifying Physician: 2 Medical Examiner: On an	To the best of my knowled the basis of examination d manner stated.	dge, deat and/or in	h occurred at the tim vestigation, in my op	e, date and plac inion, death occ	e, and due to the ourred at the time, o	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	· A A		29c. License			29d. Date	e signed (Month	n, Day, Year)
			) 00x, C	ESIA) NYS		174	2634	4	No	y 21	2004
			30. Name and address of person who complete	d cause of death (Item 23	a) (Type,	Print)	E RA	CT MOR	E) M	10 20	202
	Sta	tė	31. Date filed (Month, Day, Year) DEC 0 7 2004	32. Registrar's Signatur		osde	- 171)	, , , , ,	- /		
	Registr	ar	DEC 0 1 2004	Jan Jan	7						

State of Maryland / Department of Health and Mental Hygien 2 1 11.

			1 - For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment of <i>tificate o</i>	Health a	and Me	ntal Hygie		38668
4	Physici /Medic		Decedent's Name (First, Middle PIN		715R	1			2.	Date of Death Month	Day Year	
	Examir		4a. Facility Name (If not institution	-		-11-1	4b. City, Town	, or Location	of Death Colui	mbia	4c. County of De	
	Funeral	,	5. Social Security Number	ard County Ge	eneral Hosp 7. Age (In yrs. I		If Under 1 Yea	ar If Under			9. B	Howard inhplace (State or Foreign
	Director		216-02-0145	1□M 200F		3 Yrs.	Months Day	s Hours		Date of Birth (Month, Day, Ye January 7		Country) Thailand
	and w		Usual Residence of Decedent  10a, State 10b, County		10c City	, Town or Lo	cation					10d. Inside City Limits
	Manyli f eho	tor	Maryland	Howard		, , , , , , , , , , , , , , , , , , , ,		Ellicott C	City			1 □ Yes 2 No
	h the	irec	10e. Street and Number				10f. Zip Code		,	10g.	Citizen of What C	Country?
	23a c	raiD	4381 Montgomery	Rd.				21	1043			J.S.A.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28a-f ehow appriants or other traumatic event, the Medical Evant for must be notified at ance.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	Armed For	2 No		Was Decedent of f Yes, specify Ci I ☐ Yes 2 N			y Yes or No- an, etc.)	14. Race - Am Black, Wh Specify:	
5-0	72 ho	eted	15. Deceden (Specify only higher			(Give	lent's Usual Occ	e durina mos	st of working	165	. Kind of Busines	s/Industry
121	within ane. then "	du	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life. I	DO NOT use reti	<sub>red)</sub> Homemal	ker		Ov	vn Home
	Hygin other	Be Co	17. Father's Name (First, Middle,	Last)				1		irst, Middle, Maid	den Sumame)	
/lan	vid be Mental rrked ric ev	To B	S	ubin Silidate						Nuon (	Gompawong	)
Maryland	2 sho and h	i	19a. Informant's Name/Relations								ty or Town, State,	Zip Code)
	1 and Health em 27 ther tu	1	Ms. Somkit L	al Da	aughter		4381 Monto sition (Name of	omery R	d. Ellicot Date	t City, Maryl	and 21043  Location - City o	r Town State
Baltimore,	it. Pages rtment of I rtant: If its njury or o		1 Burial 2 Cremation  4 Donation 5 Other (S	pecify)	State C6	emetery, cren County C	remation S	Services,	Inc. <sup>12/0</sup>	7/2004		lle, Maryland
Ba	permi Depar Impo eny ir		Melayero	herbrie	ht mas	293	387	k Funera I Old Col	l Home, umbia Pi	ke Ellicott C	ity, MD 210	
	Physician /Medical		23a. Part 1. Sever the disease, or shock, or heart allive. List Immediate Cause (Final disease or condition resulting in death)	a	fused the death ach line. or as a consequ	C				RY 3 15 L	EASE	Approximate Interval Between Onset and Death
Fr.	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	ur as a consequ	enice of).						
8760,	cate be executed physician and the burial-transit	ai Examiner	that initiated events resulting in death) Last	c. Due to (d	or as a consequ	ence of);						
687	ificate g phys as the	edicai		d								
P.O. Box	The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ ¶o 9 ☐ Unknown		rth 2 ☐ Fetal ant at time of de	death 3 [	Ectopic pregnar Other (specify)	осу			23d. Date of de Month	elivery Day Year
	uires that the signed by d be detac	by Pł	Part II. Other significant condition	-		•	, -	given in Part I.		23e. Did tobacc	o use contribute t	to the cause of death?
rds	w require been sig should b	ed b	Typer ter	sion C	erd,	my	" pot	4		1 🗌 Yes	2□No 3□P	robably 4 Unknown
of Vital Records,	The taw ri	Completed						·		24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
Vita	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			- 10	lth ar		heck onlone		
o	S D	1: To	1 Yes 2 No 27. Manner of Death	28a. Date o	f Injury	F/Outpatien 28b. Time of	3 000	4   140	-	5 Residence Describe how in	6 Other (Speniury occurred	ecify)
ion	nding ath. r: Afte e fune	atior	1 Natural 5 Pendin 2 Accident investig	g (Month	n, Day Year)	Injury	28c. In W M 1	ork? ⊒Yes 2.∐l			,,	
Division	s after des la Director ad in by th	Certification:	3 Suicide 6 Could in determined	ned 28e. Place	of Injury - At hor g, etc. (Specify,	me, farm, stre	eet, factory, offic	Ð	28f.	Location (Street City or Town, St.	and Number or R ate)	lural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier Certifyin (Check only one)	g Physician: To the l Examiner: On the ba and mann	sis of examinati	vledge, death on and/or inv	occurred at the estigation, in my	time, date an opinion, dea	d place, and th occurred a	due to the cause at the time, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To t To t	M	29b. Signature and title of certifier	-/1				289		/	2-3-6	
	3		30. Name and address of person	who completed cause	of death (Item	23a) (Туре. I	Print) PR	11/22	n -	SANI		10708
	Sta Registr		31. Date filed (Month, Day, Year)	40	gistrar's Signat					-		
DH	MH 17 Rev 1/2		DEC 0.7	2004	en l	× An	seles.		·			

State of Maryland / Department of Health and Mental Hygiene

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	3		edent's Nam	e (First, Middle, L	ast)					2. Dete of De	eth		. Time of Deeth		
	Physician /Medical	1166	BRA L	YNN ROS	SI					Month Decemb	Day er 2, 2	Year 004	7:50 am		
	Examiner	4n Pas	cility Neme (/	f not institution, gi	ve street end nu	mber)			4b. City, Town, o	r Location of Deeth					
1			erry La	ane Nurs	ing Home	2			Laure	L	Princ	e Georg	ge's		
	Funeral	5. Soci	al Security N		Sex	7. Age (In yrs.	lest birthday)	if Under 1 Ye			h v. Year)	9. Birthplace	(State or Foreign		
	Director		-66-9		1□ M 2□F	47	Yrs.	WIOTIETS	ys Tiodis IVIII	Aug. 24	, 1957	PA			
	p .		Residence of			10- 04		-4:				101			
	anyla show	10a. St	919	10b. County			y, Town or Loc	ation					Inside City Limits		
	Ba-f	MD		Anne Arı	undel		denton	,					1□Yes 2□No		
	or 2	10e. St	reet end Nur					10f. Zip Cod			10g. Citizen of	What Country?			
	72 hours after death with the Maryland nature!', or flems 23a or 28a-f show dical Examiner must be notified at steed by Eumeral Director	/19		oring Dr				211			U.S.A.				
	ar de them	11. Ma	ritel Status		12. Was Dece Armed Fo	edent Ever in U	,S. 13. W	as Decedent of Yes, specify C	of Hispenic Origin? ( Juben, Mexican, Pue	(Specify Yes or No orto Rican, etc.)	- 14. Rad Bla	ce - American I ck, White, etc.	ndian,		
36	s afts			ed 2 Married 4 Divorced	1 ∐ Yes If Yes, Gir Year or D	/0	1	□Yes 2【数】	No Specify:		Specif	v: White			
8	ed within 72 hours a ygiene.  Per than "naturel", c.  ft, the Medical Exat	32	***************************************	15. Decedent's E		ales:	16a Doorde	ent's Usual Oc	ounation		16h Kind of B	usiness/Industr			
5	in 72			ify only highest gr	rede completed)		(Give k	ind of work do	ne during most of w ired)	orking	TOD. KING OF B	usii10ss/11luusii	У		
12	filed within Hygiene. ther then ent, the Me	Gra	nentary/Seco ide 12	ndary (0-12)	College (	I-4or 5+)		fice Ma			Acc	ounting	7		
0	Hygin Hygin			(First, Middle, Las	t)					ame (First, Middle,			3		
<u>a</u>	Mental H Mental H Irked oth stic ever	Tho	mas E	. Geib					Dorot	hy Louis	e Tezak				
Maryland 21215-0036	should be fand Mental hard Mental to marked of turnatic even		formant's Na	me/Relationship	(Type, Print)		19b. Mailing	Address (Stre	et and Number or F	Rurel Route Numbe	er, City or Town,	State, Zip Cod	de)		
	and 2 saith a n 27 is	D.	Louise	e Geib	/ mothe	er	328 5	Thomas	Drive La	aurel, Ma	rvland	20707			
ē,	f Hear f Hear othe		ethod of Disp				Place of Dispos emetery, cremi	ition (Name of		Date	20c. Location		State		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If frem 271s marked other than "naturel", or frems 23s or 28s-f show nimportant: If them 271s marked other than Defeat Examiner must be notified at once.  To Re Completed by Euneral Director			☐ Cremation 3 [ 5 ☐ Other (Speci		State	ton S.		•	12/6/04	Hershe	V. PA			
Ħ	permit. Page Department of Important: If any Injury or DDCB.	1		neral Service Lice			22.	Name and Ad-	dress of Fecility			11			
ä	perm Depa Impo any i		1	1		/ MOOT	De	onaldsc	n Funeral						
		23a P	art1 Enter th	ne disease oricon	nolications that o	_ / M007			ott Avenu				20707 proximate		
	Physician	sl	hock, or hea	rt failure. List only	one cause on e	ech line.			tying, such as cardi			Inte	erval Between set end Death		
	/Medical	Immed	liate Cause (	J Final	T :	D : 1		1 - 1 - 7 -	\						
	Examiner	disees resultir	ediate Cause (Final see or condition a. Liver Failure (alcoholic)  Due to (or es a consequence of):												
	ě					Due to (o	res a consequ	ence of):				1			
	rificate be axecuted ng physician and a as the burial-transit	Canua	atially list sec		b	Due to (o	r es e consequ	ence of):							
oʻ	axec an an rial-tr		ntially list cor leading to im Enter Unde (Disease or	mediate		-20.00									
68760,	The law requiras that the death certificate be assocuted that has been signed by the attending physician and page 2 should be detached for use as the bural-transit completed by Physician/Medical Examit	Ceuse that init	liated events		C	Due to (o	r as a conseque	ence of):							
89	iffica g ph as th	resultin	ig in death) L	ast			1	,.							
Box	aath cer attandin I for usa				d							İ			
	at the death ced by the attendietached for usi	Part II.	Other signifi	cant conditions	contributing to de	ath but not resi	ulting in the und	derlying cause	given in Part I.	23b. Did t	obacco use co	ntribute to the	cause of death?		
P.0	that the da ed by the a detached i							, ,			res 2□ No		y 4K Unknown		
	as thatigned be del		ardio	nyopathy											
of Vital Records,	w require should the s	, p	enal I	ailure						24a. Was	en autopsy med?		utopsy findings le prior to		
ပ္ထ	aw re Is bed 2 sho		CHAI	allule						ponos	mou:		tion of cause		
æ	The law requir									101	os 2XXVIII	1 □ Ye	s 2XXXIIo		
ţ				ed to medical					26. Place of De	eath (Check only o	ne)				
>	S 0 0	exa	miner? ]Yes 2⊠]	Щo	Hospital:	npatient 2 🗆	ER/Outpatient	3□ DOA	Thos:	Home 5 ☐ Resid		er (Specify)			
	g Ph er thi neral		ner of Death		28a. Date of	of Injury h, Day Year)	28b. Time of Injury	28c. Ir	jury at vork?	28d. Describe h					
Ö	Attending or death.  ector: After by the fune iffication	2	Accident	5 Pending investigetio	n	., Day rour,	injury		☐ Yes 2 ☐ No						
Division	Atternation of the parties of the pa	3 L 4 L	] Suicide ] Homicide	6 Could not be determined	28e. Place	of Injury - At ho	me, farm, stree	et, factory, offic	ю	28f. Location (S City or Tow		er or Rural Ro	ute Number,		
Ö	tal or Attending P rs after death. el Director: After ti led in by the funera Certification:				Don'd.	.g, 0.0. (0,000.)	,				., 0.0.0,				
	Hospital 24 hours Funerel staty filled			1XXCertifying Pi	nysician: To the	best of my know	wledge, death o	occurred at the	time, date and plac y opinion, death occ	e, and due to the d	ause(s) and ma	inner as stated	l.		
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification: 1		ne)		and manr	er stated.	.orr end/or mive								
	within 2 To the comple	29b. Si	gnature and	title of certifier	( , , = 1	6-1		29c. Lice	nse number	2	29d. Date signe	d (Month, Day,	Year)		
	/			Uy	ayi	MI)		D	45217		Decemb	er 2, 2	004		
	15			ess of person who		e of death (Item	23e) (Type, P	rint)							
	, -			e Ajayi,	M.D. 6	201 Gre	enbelt	Road S	uite Ul5	College	Park,	MD 207	40		
	State	31. Det	e filed Mont	h Par Year		egistrer's Signe		/							
	Registrar			• 2004	A Continue	No. of Street	10 1	Da V							

DHMH 16 Rev 6/95

ORIGINAL

			_ For	State of Mar	yland / Dep	artment of H	lealth and M	•	•		38670
			1 - State Registrar	and a	Се	rtificate of	Death	Reg	ı. No.	7 (	
	Physici	an	1. Decedent's Name (First, Middle, L JOSEPHINE		REIGLE			Month		/ear	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, or	r Location of Death	DECEMBER	02 20 4c. County of	04 Death	18.00
	Examin	er	UnivERSITY OF MARYE	_	CENTER		LTIMORE		,		
	Funeral			Sex 7. Age (	In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear)	9. Birthpl	ace (State or Foreign
	Director		214-52-4454	1 M 2 F 56	Yrs.			Sept 6,		PA	
	land		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or L	ocation				10	d. Inside City Limits
	Mary Fied F	tor	Maryland Prince	George's		Mor	ningside				1 ☐ Yes 2 No
	h the or 28a	Funeral Director	10e. Street and Number	0		10f. Zip Code	HIHEBIUC	100	. Citizen of Wh	nat Count	ry?
	23a c	al	6708 Larkspu <b>r</b> F	₹oad		2074	6		U.S.A		
	ar dea	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		White, e	itc.
36	rs afte		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕅 Divorced	1 ☐ Yes 25 VNo If Yes, Give 171 Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Nat Specify:	ive	American
21215-0036	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Itams 23a or 28a-f show thar than "hedical Eva" il ar mast be redified at	Completed by	15. Decedent's	Education	16a. Dece	edent's Usuai Occup	ation	16	ib. Kind of Busi	ness/Ind	ustry
212	thin 7.	ple	(Specify only highest g	grade completed)  College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of work d)	ing			
2	ed wil	Con	10th		S	ales Cler					Company
<u>n</u>	be be be be	Be	17. Father's Name (First, Middle, Las	*				e (First, Middle, Ma		)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygjene. Importants if item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Ever Last met Le Indilled at 2008.	ဥ	James D. Hoo	_	aran a with mal	ing Address (Street	Almeda			tata Zia	Mille
<u>s</u>	id 2 si th an traur		19a. Informant's Name/Relationship Raymond F. Burd	lette, Jr.	670	Q Tarkanı	r Dood Mo	ar noute ivamber, t	any or Town, St	ate, zip	2000)
<u>6</u>	s 1 and if Health itam 27 othar ti		20a. Method of Disposition		20b. Place of Disp	8 Larkspu osition (Name of Imatory or other place	Decei		c. Location - C		vn, State
ê E	Pages nent of int: If it		1 ☐ Burial 2 X Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec	Publical linii State	Lee Cre		200	24	Clinton	Mo	ruland
Baltimore,	permit, Page Department of Important: If any injury or ange.		21. Signature of Funeral Service Lic			2. Name and Addres	ss of Facility Le	e Funeral	Home.	Tnc.	. yrand
m	8 8 E 8 8		16/Q	luge Mi	01340	6633 014	Alexandri	a Ferry F	load C1:	into	n, Μυ20735
			23a. Part I. Enter th seas, or c shock, or heart failure. List on	mplications that caused the	e death. Do not er	iter the mode of dyin	g, such as cardiac	or respiratory arres	t,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, VENTEI	CULAR A	RRHYTHMI	Α				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):						
	«	<u>.</u>	Sequentially list conditions,	b. ONG IN	2 CARDIC	GENIC SI	HOCK			_	9 HOURS
	ted Isit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			IL SHOCK					9 HOURS
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. ONGOIN  Due to (or as a c		IL SHOCK					1 40083
760,	te be e ysiciar ne buri	calE		a. PNEN	PINON						
9	tificat ng phy as th										
ŏ	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2 [		□Ectopic pregnancy			23d. Date		*
. B	at the dea by the att tached fo	Sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Onknown	4□Pregnant at tim 9□Unknown		Other (specify)			Month	n l	Day Year
о. О	hat th d by detach	Phy	Part II, Other significant conditions	contributing to death but a	not resulting in the	indoching cause and	on in Part I	23e Did tohar	co use contrib	ute to the	cause of death?
Records,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	d by	GASTROINTES			andbriying cadso givi	on in rain.			_	bly 4 Dunknown
Ö	w require been si should?	ete						24a, Was an	24h Wa		cu findinge available
Ř	The lav	Completed						autopsy performe	d2 dea	or to com ath?	sy findings available pletion of cause of
Vital			25. Was case referred to medical				26 Place of Death	1 ☐ Yes 2 € h (Check only one)	No 1	Yes 2	2 No
>	iysiclan: iis certifica director, p	o Be	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Othe	er: 4 Nursing Ho		e 6 ∏Other	(Specify)	
o L	ding Phy h. After thi funeral	T :u	27. Mannel of Death	28a. Date of Injury (Month, Day Y	28b. Time o		/ at	28d. Describe how			
Š	andin sath. or: Afr	atlo	1 Natural 5 Pending investigation	ion	out, injury		Yes 2 □ No				
Division	I or Attand after death Diractor: ,	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		<ul> <li>At home, farm, st 'Specify)</li> </ul>	reet, factory, office		28f. Location (Stree City or Town, S	et and Number State)	or Rural	Route Number,
	urs af		00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
	e Hospital or At 124 hours after d a Funaral Dirac letely filled in by	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best of r aminer: On the basis of ex and manner stated	kamination and/or ir	th occurred at the tin nvestigation, in my of	ne, date and place, pinion, death occurr	and due to the caus ed at the time, date	se(s) and mann a and place, and	er as sta d due to t	ted. the cause(s)
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illed in by the funeral director,	Me	29b. Signature and title of certifier	The manner states		29c. License	a number	29d	. Date signed (	Month, D	ay, Year)
	~ ~	/		12		Do	058914	Da	CEMBER	02	2004
)_	15		30. Name and address of person wh	T	th (Item 23a) (Type						
	( 1 Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature			- TOUE	rip	-16	
	Registr	ar	DEC 0.7.3	2004 /	ra G	fra 4	,				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State of	of Mary	land / Depa <i>Ce</i>	artment of rtificate of		and Me	•	giene Reg. No.	004	38671
	Physici	an	1. Decedent's Name (First,	Middle, La		1.00	dsor				2. Date of De.	ath Day	Year	3. Time of Death 4, 20 pM
N.	/Medic		4a. Facility Name (If not in:	) stitution, giv			4301	4b. City, Town	or Location of	of Death	12	4c. Cc	2004 ounty of Death	
			Genesis					Balti		0.11			ltimo	
	Funeral Director		5. Social Security Number		Sex 1 □ M 2754F	7. Age (In	yrs. last birthday) 88 Yrs.	If Under 1 Year Months Day		Min.	8. Date of Bird (Month, Da		Col	nplace (State or Foreign untry)
	_		220-09-0840 Usual Residence of Deced								Sep 4,	1916	MD.	
	f ehow	ō		County		100	c. City, Town or Lo	ecation						10d. Inside City Limits 1 ☐ Yes 2 No
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Director	MD Ba 10e. Street and Number	ltimo	re	1 5	Cowson	10f. Zip Code			T	10g. Citizer	n of What Co	untry?
	eth w	rait	535 Piccadil	ly I				21204					ed Sta	
36	or its	by Fune	11. Marital Status  1 Never Married 2[ 3 Widowed 4 Di		12. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2.500 ive		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ €	ban, Mexican,	gin? (Spec i, Puerto F	city Yes of No Rican, etc.)		Race - Amer Black, White pecify:	e, etc.
20	"netural",	sted		cedent's E	ducation ade completed	,	16a. Dece	dent's Usual Occ kind of work don	upation e during most	t of workin	a	16b. Kind	of Business/l	
21215-0036	s i end 2 should be filed within ' f Heelth and Mentei Hygiene. Item 27 is merked other then "I other traumatic event, the Med	Completed	Elementary/Secondary (			1-4or 5+)	Secre	DO NOT use reti	red)		9	Gouch	ner Col	llege
pu	be file tei Hys d othe event,	Be	17. Father's Name (First, A	fiddle, Las	)			•	18. Mother	r's Name	(First, Middle,	Maiden Su	mame)	
Maryland	hould d Men marke	ဥ	John Lee Sm 19a. Informant's Name/Re		(Type, Print)		19b. Mailir	ng Address (Stre	Laura		berts	ar. City or To	own State Z	io Code)
	es 1 end 2 s of Heeith an if Item 27 is in or other traus	1	William Ric					Piccadil				MD 21	and.	,, , , , , , , , , , , , , , , , , , , ,
Baitimore,	ges 1 e l of Hee If Item or othe		Da. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Dec 7								20c. Location - City or Town, State			
III.	permit. Peges Depertment of Importent: If if eny injury or o		`4 □Donation 5 □O	1 Burial 2. Cremation 3 Hemoval from State Dec 7									ville,	MD
Ba	Depermination of the permitted of the pe			Hal	W_	Mod	088C	_	n and	Fune				MD
	Physician /Medical Examiner	her	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to arrived any, leading to arrived any.	e. List only	a. Due to	each line.  TEU  (or as a cor	nsequence of):	MIAC	(NF)	Cardiac or	TION	rest,		Approximate Interval Between Onset and Death
68760,	ficate be executed physicien end is the burial-trensit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to	(or as a cor	nsequence of):							
P.O. Box	thet the deeth certifi ed by the attending detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregn in the past 12 months 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			birth 2 ☐ naunt at time	Fetal death 3	Ectopic pregnar Other (specify)	су			230	I. Date of deli Month	very Day Year
	8 5 6	d by Pr	Part II. Other significant o	onditions	contributing to o	leath but no	t resulting in the u	nderlying cause (	given in Part I.		1 77	obacco use 'es 2 1		the cause of death?
I Records,	The lew ate has by pega 2 sh	Completed					<u> </u>					an 2 sy rmed? 2 No	!4b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of
of Vital	Physicien: Th this certificate rei director, peç	Be	25. Was case referred to examiner?	nedical	Hospital:				than _		(Check only o			
	D = 0	on; To	1 Yes 2 No  27. Manner of Death 1 Natural 5	Pending	1	Inpatient of Injury oth, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Inj	ury at ork?	2	e 5 🗆 Resid 8d. Describe h			ify)
Division	To the Hospitel or Attsndir within 24 hours efter death. To the Funeral Director: Al completaly filled in by the fu	Certification;	2 Accident 3 Suicide 6 4 Homicide	investigation Could not to determined	28e. Plac	e of Injury - ling, etc. (Si	At home, farm, str Decify)		∏Yes 2∐N		8f. Location (S City or Tox	Street and N m, State)	lumber or Ru	ral Route Number,
	Hospite 24 hours Funeral staly filled	Medical C	29a. Certifier 1 ☐ € (Check only 2 ☐ M	ertifying P edical Exa	miner: On the I	e best of my pasis of examener stated.	r knowledge, death mination and/or in	n occurred at the vestigation, in my	time, date and opinion, deatl	d place, and	nd due to the o	cause(s) and pla	d manner as ace, and due	stated. to the cause(s)
	To the within To the	₩ E	29b. Signature and title of	certifier				29c. Lice	nse number			29d. Date s	igned (Month	, Day, Year)
	57		> nme		-wno			DU	1794	7		DE	2	2004
	X		30. Name and address of		completed cau		(Item 23a) (Type, US OSU)	•	UE TO	Olus	on u	40	717	204
ì	Sta Registr		31. Date filed Month Pay	2004	32. I	Registrar's S	Signature	book					· · · · · · · · · · · · · · · · · · ·	

			1 - For State Registrar	State of Ma	aryland		artment of H Tificate of L		d Mental H	ygiene	nn h	38672			
	Physici /Medic		1. Decedent's Name (First, Middle, La	R. S.	ous	A			2. Date of I Month	Death Da	y Year 5 04	3. Time of Death			
	Examir		4a. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, or	Location of D	eath	4c	. County of De				
			134 Goucher Terr		4.			hersbu			Monte	gomery			
L	Funeral Director		223-45-4653	Sex 7. Ag	53	ast birthday) Yrs.	If Under 1 Year Months Days		Win. June	23, 19	9. B	irthplace (State or Foreign Country) Brazil			
	/land	1	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation		···			10d. Inside City Limits			
	a-f sh	to	Maryland Monto	omery			Gaithe	ersburg	ī I			1 ☐ Yes 2 No			
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What (	Country?			
	ath w		134 Goucher Te					20877			ted Sta				
36	be filad within 72 hours after death with the Maryland ital Hygiene. In the matural, or Itams 23a or 28a-f show avent, it e Medical Examinat must be multiped at	by Funeral	11. Marital Status  1 Never Married	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		'	Vas Decedent of Hi f Yes, specify Cuba Y Yes 2□ No	Coosifu	? (Specify Yes or I uerto Rican, etc.) razilian	No-	14. Race - Arr Black, Wh Specify:				
9	72 hou 'natura	ted	15. Decedent's E	ducation			lent's Usual Occupa	ation		16b. K	ind of Busines				
21215	i within 7: jiene. r than "n	Completed	(Specify only highest gi	College (1-4or 5	i+)	life. I	kind of work done o DO NOT use retired, us Operat	)	working			ortation			
Maryland 21215-0036	ould be filad a Mental Hygie arkad other i atic avent, II	To Be C	17. Father's Name (First, Middle, Las Clerio Vieira		- '				Name (First, Midd a de Lo	lle, Maiden	Sumame)				
	d 2 sho th and th and 7 Is m traum	-	19a. Informant's Name/Relationship Solange Sousa /				g Address (Street a								
Baltimore,	8° = 2		20a. Method of Disposition  1  Burial 2 Cremation 3 [  4  Donation 5 Other (Speci		ce	metery, cren	sition (Name of natory or other place e Cremato		Date /5/04		ocation - City o	or Town, State			
Baltir	permit. Pa Departmen Important: any njury		21. Signature of Funeral Provice Lies		00	Ŕ	Name and Address	a1 Facility d	Crematio	on Se	rvices	· ·			
			23a. Part1. Enter the disease, or con	nplications that caused	the death.		33 Gist A				MD 20	0910 Approximate Interval Between			
	Pnysician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mmediate Cause (Final disease or condition											
90,	cate be executed physician and the burial-transit	I Examiner	Sequentially list conditions. The leading to the models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	+a	sta ence of	tic	to 1	sone			3 months			
D. Box 68760,	death certifi e attending d for usa as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d.  23c. If yes, outcome  1 ☐ Live birth  4 ☐ Pregnant at  9 ☐ Unknown	2 Fetal	death 3□	Ectopic pregnancy Other (specify)				23d. Date of de Month	elivery Day Year			
ds, P.O.	ss that the		Part II. Other significant conditions	contributing to death b	ut not resul	-	nderlying cause give	on in Part I.				to the cause of death?			
Vital Records,	e law has b je 2 sl	Completed by	Conjest	i i i i i i i i i i i i i i i i i i i		- F CC	11000		24a. Wa		24b. Were a	autopsy findings available completion of cause of			
a		e Co	25. Was case referred to medical						1 ☐ Yes	2. No		s 2 <del>01</del> 0			
		OB	examiner?	Hospital:	nt 2∏ F	R/Outpatien	Othe		Death Check on ng Home 5 2 1 e	-	6 □Other (Se	aniful			
on of	Attanding Physideath.  actor: After this by the funeral di		27. Manner of Death  1 ANatural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day		28b. Time of Injury	28c. Injury Work	at	28d. Describe			<del>о</del> спу)			
Division of	l or Attan after dea Diractor	Certification:	3 Suicide 6 Could not to determined	De Place of Inju	ury - At hon c. (Specify)	me, farm, stre	eet, factory, office		28f. Location City or T	(Street an own, State	nd Number or F	Rural Route Number,			
	To the Hospital or Attanding F within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer.	edical C	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and pl vinion, death o	ace, and due to the	e cause(s) s, date and	and manner a place, and du	is stated. le to the cause(s)			
	To th within To thi	Me	29b. Signature and title of certifier				29c. License	number		29d. Dat	te signed (Mon	eth, Day, Year)			
)			Disette	e UL	\		000	5926	14	12	2-05	-04			
	V		30. Name and address of person who Giselle Meny,	M-0 56	eath (Item	23a) (Type, 1 5 Mel	Print)	ve /	Bethes d	a, N	0 20	817			
:	Sta Registr		31. Date filed North. (ay, yeaz 00	32 Registra	ar's Signatu		Sparker					-			

State of Maryland / Department of Health and Mental Hygiene 1- State Registra/AMEND TTEM#5 PER FH C838 12/ Ce/tilicate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12/06/2004 Paul Joseph Slater 3:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1221 Hillside Road Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Yrs. Director 60 05/19/1944 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avent, the Medical Examiner must be notified at Director 1 TYes 2 XNo Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Hillside Road or itams 23a 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 2 Specify. 3 Widowed 4 Divorced White natural ed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Complet filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Produce Trimmer Giant Food s 1 and 2 should be filed voil Health and Mental Hygie Itam 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Walter Slater Catherine Dorothy Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Slater/Mother 1221 Hillside Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If Its any injury or ot once. Burial 2 Cremation 3 Removal from State Glen Haven Mem Pk 12/09/04 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophue Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of): sician Box 68760 Physician/Medical the ! IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No Division of Vital 1 Yes 2 No the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Tyes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Certification: 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a a Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3708 mountain Rd Pasadema nristopher a Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 0 7 2004

		1 - For State Registrar	State of Maryla	nd / Dep		Health and	Mental Hy	giene 00 4	38674
Physicia /Medica Examine	al	1. Decedent's Name (First, Middle, Las  THELMA  4a. Facility Name (If not institution, give  Bayview Med  5. Social Security Number  6. Se	street and number)	STEF	Balt			Day Ye 4 2 to 4c. County of E B a (ti	Jeath more City
Funeral Director		213-14-2870 Usual Residence of Decedent	□ M 2 XF 85	Yrs.	Months Days	Hours Min			Birthplace (State or Fore Country) aryland
the Marylar 28e-1 show	rector	MD 10b. County n/a	10c. 0	Balti				10g. Citizen of What	10d. Inside City Lim 1 ☑ Yes 2 ☐ I
be filed within 72 hours after death with the Maryland ital Hygiene. od other then "netural; or items 23e or 28e-1 show event, the Medical Examiner must be neithfied at	by Funeral Director	264 South Boul  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	din  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		2122 Was Decedent of H f Yes, specify Cub.	dispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	USA 14. Race - A Black, V	American Indian, White, etc.
ad within giene. er than	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation	16a. Dece (Give life. Ass	dent's Usual Occup kind of work done DO NOT use retired embly L	ine		16b. Kind of Busine Bendix	
should nd Mer marke umatic	lo Be	Charles Dasch 19a. Informant's Name/Relationship (7)	ype, Print) SON	19b. Mailir	ng Address (Street	Mary	Dinges	Maiden Sumame) er, City or Town, Stat	e, Zip Code)
of Hea of Hea if item		Timothy J.Stefa  20a. Method of Disposition  1 \textbf{\textit{Z}} Burial 2 \textsquare Cremation 3 \textsquare  4 \textsquare Donation 5 \textsquare Other (Specify)	20b.	264 Place of Dispo	S. Boul	din St.	, Balt	imore, M 20c. Location City Baltimor	D 21224 or Town, State
permit. Pag Department important: i any injury o once.		21. Signature of Funeral Service Licens  When the service Licens		22	. Name and Addre	ss of Facility	oseph I	N. Zanni	noJr. FH ,MD 21224
p gg p	cal Examiner	23a. Pairt. Enter the disease, or comply shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused the deadle cause on each line.  a. Due to or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	quence of):	etellar	222	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
death certif	rnysicialiymed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	(3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feti 4 □ Pregnant at time of o 9 □ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
igne igne bed	2	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the ur	derlying cause give	en in Part I.	23e. Did to		to the cause of death?
		05 Western March 1971					24a. Was a autop: perfor 1 \( \t \) Yes	sy prior t med? death	autopsy findings availat o completion of cause o ? es 2 \(\sum \) No
Attending Physician: The la redeath. ector: After this certificate has by the funeral director, page 2 by the funeral director of the funeral director	2	25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	er: 4 □ Nursing H		ence 6 □Other (S) ow injury occurred	pecify)
		3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy)			City or Town	,	
To the Hospital or within 24 hours atte To the Funeral Dir. completely filled in IMAdical Cort	- (	29a. Certifier (Check only one)  1 **Certifying Physical Examination (Check only one)  2 **Medical Examination (Check only one)	sician: To the best of my knorer: On the basis of examination and manner stated.	owledge, death ation and/or inv	estigation, in my op	inion, death occu	rred at the time, d	late and place, and d	ue to the cause(s)
To To Som		30. Name and address of person who co	mpleted use of death (Iter	). n 23a) (Type, F	29c. License	099		12/4/2	2004
State Registrar		31. Date filed (Month, Day, Year)	32. Registrar's Signa		1 Con	ter s	Baltim	ore, N	Paryland

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State State Registrar		partment of Health a ertificate of Death	nd Mental Hygie	ZHILL 38675
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	Delores J. Speece  4a. Facility Name (If not institution, give street and	(cumber)	4b. City, Town, or Location of	December	4c. County of Death
	Examin	ier	Franklin Square He	soital Conte	1 Rosedile	Death	Baltimore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	ay) If Under 1 Year If Under 2	Min. (Month, Day, Y	9. Birthplace (State or Foreign
	Director		192-24-2927 1□ M 2 X  Usual Residence of Decedent	75 Yrs		Aug. 4,	1929 Minnesota
	ryland how		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Ba-f s	Director	Maryland N/A		Baltimore		1 M Yes 2 □ No
	with t	Ö	10e. Street and Number 2801 Shirey Avenue		10f. Zip Code 2 1 2 1		Citizen of What Country?
	death	nera	11. Marital Status 12. Was D	Decedent Ever in U.S. 1 1 Forces?	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,		14. Race - American Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show is Medical Exaith at mast be notified at	by Funerai	1 Never Married 2 Married 1 Yes.	es 2 No . Give	1 ☐ Yes 2 No Specify:	r dello nicati, etc.)	Black, White, etc.  Specify: White
9	2 hour	ted t	15. Decedent's Education	or Dates:	cedent's Usual Occupation	16	b. Kind of Business/Industry
215	ithin 7 ne. nan "n	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e <i>d)</i> ( <i>G</i> life (1-4or 5+)	ive kind of work done during most a. DO NOT use retired)	of working	
2	filed w Hygier other th		12th Grade  17. Father's Name (First, Middle, Last)		Homemaker	's Name (First, Middle, Mai	Own Home
an	Mental Mental arked o	To Be	Louis B. Aanrud				hnson
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural; or Items 23a or 28a-4 show any injury or other traumatic event, I've Medical Examinating the rollited at once.		19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street and Number		
e,	1 and Health em 27 ther tr		Mr. Michael Schmitt  20a. Method of Disposition		16 Overland Aven	1	e, MD 21214 c. Location - City or Town, State
πor	Pages nent of I int: If its ury or o		1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	JIII State	sposition (Name of trematory or other place)  Crematory 1:		Baltimore, Maryland
Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licensee	Buyeren	22. Name and Address of Facility		
<u> </u>	88 5 8		Manighty.	(	9705 Belair Rd.	, Baltimore,	
	Physician		23a. Hrt1. Enter the disease, or complications the shock, or heart failure. List only line cause of immediate Cause (Final	on each line.			Approximate Interval Between Onset and Death
	/Medical		resulting in death)	to (or as a consequence of);	atory Distre	ss synaron	ne_
П	Examiner	<u>.</u>	Sequentially liet conditions, b	Monary to (or as a consnce of):	- brosis		
	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	DUS			
o,	ate be executed hysician and the burial-transit	Еха	that initiated events resulting in death) Last C Due	to (or as a consequence of):			
8760	eath certificate be executed attending physician and for use as the burial-transit	dical	d				
9 xo	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	outcome of pregnancy			23d. Date of delivery
m ·	death	iciar	in the past 12 months?	egnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
о. О	res that the de igned by the a be detached f	Phys	9 🗆 Onknown	nknown			
ds,	signe signe d be d	by	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Record	aw require s been sig s should t	Completed	24 422000 B	tery Disa	2ase	24a. Was an	24b. Were autopsy findings available
	The tay ate has page 2	mo:	9	icig Disc	-400	— autopsy performed 1 ☐ Yes 2 ☑	prior to completion of cause of death?
Vita	ician: The certificate harector, page	Be	25. Was case referred to medical examiner?			of Death (Check only one)	
	Phys r this ral dir	1: To		☐ Inpatient 2☐ ER/Outpat ate of Injury 28b. Time		sing Home 5 Residence	
on	Attending death. ctor: Afte y the fune	atior	1 ☑Natural 5 ☐ Pending (M 2 ☐ Accident investigation	ate of Injury fonth, Day Year) 28b. Time Injury			njary occurred
Division of	il or Attending Ph after death. Director: After th d in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Plants	ace of Injury - At home, farm, illding, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	pital o		29a. Certifier 1 Certifying Physician: To	the heet of my knowledge, do	eath occurred at the time, date and		
	To the Hospital or Attending Physician: which 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	(Check only 2 Medical Examiner: On the	e basis of examination and/or nanner stated.	investigation, in my opinion, death	occurred at the time, date	and place, and due to the cause(s)
	To t withi To t	Σ	29b. Signature and title of certifier	July 1	29c. License number	7 J	Date signed (Month, Day, Year)
	4		20 Marro and address of arross who approved	uy //· L	2. DOO58 F	/   /	12-5-04
	0		30. Name and address of person who completed confidence of the second of	0 Franklin	Square Drive	Baltimore	mo 21237
•••	Sta Registr		31. Date filed (Month, Day, Year) 32	2. Registrar's Signature	& look		

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate of			giene 04	38676	
	Physic /Medi		1. Decedent's Name (First, Middle, Last,  Jane Sk	utch		2. Date of Death November 30 Year November 30 2004 23					
	Examir ———— Funeral	ner	4a. Facility Name (If not institution, give Orthwes + )  5. Social Security Number 214-18-3760 15	ros pital	ge (In yrs. last birthday)	Row If Under 1 Yea		ON S. B. Date of Bir	th QR	ath  M. B. Ne. inthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent	]M 2🗓F   {	83 Yrs.	Months Day	Hours Min	April Da	16, 1921	Maryland	
	ne Marylan 8a-f show oliffied at	Director	MD. Baltimo	re	10c. City, Town or Le					10d. Inside City Limits 1 ☐ Yes 2 ☒No	
	h with th	al Dire	10e. Street and Number 801 Olmstead Roa	ıd		10f. Zip Code	208		10g. Citizen of What C	•	
and 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic avent, the Medical Endminer must be notified at	by Funeral	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	No	Was Decedent of If Yes, specify Cu 1☐ Yes 2☑ No	Hispanic Origin? (Sban, Mexican, Pue	Specify Yes or No rto Rican, etc.)		nencan Indian, site, etc.	
	d within 72 ho giene. r than "natur tha Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or:	(Give	dent's Usual Occi kind of work don DO NOT use retir	during most of wo	orking	16b. Kind of Busines		
	2 should be filed withir and Mental Hygiene. is markad other than aumatic avent, the Mi	Be	17. Father's Name (First, Middle, Last)  James R. Noble				18. Mother's Na	me (First, Middle, Boane	Maiden Sumame)		
Maryland	d 2 should th and Mer 7 is marks traumatic	To.	19a. Informant's Name/Relationship (Ty Raphael Skutch	pe, Print)			t and Number or R	ural Route Numbe	er, City or Town, State, , Maryland		
Baltimore, I	ages 1 and 2 ant of Health it: if itam 27 it		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		20b. Place of Dispo	osition (Name of matory or other pl	ace)	Date	20c. Location - City of	r Town, State	
Baltir	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service License	<del>90</del>	22	2. Name and Add	ess of Facility L	oring By	4 Laurel, ers Funera stown, Mar	Maryland  Directors  yland 21133	
	cate be executed  Medical  Examiner  the burial-transit	dical Examiner	23a. Pant1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):	er the mode of dy	ing, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death	
.O. Box 68	law requires that the death certificate be execufed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnand	ey		23d. Date of de Month	Blivery Day Year	
rds, P	quires that in signed b uld be deta	Completed by Ph	Part II. Other significant conditions cor	tributing to death b	ut not resulting in the u	nderlying cause g	ven in Part I.	23e. Did to	obacco use contribute t	to the cause of death?	
of Vital R	The ate h page							24a. Was autop perfor 1 🗆 Yes		utopsy findings available completion of cause of	
	ding Physician  After this certifi funeral director	atlon: To Be	25. Was case referred to medical examiner?  1  Yes  2 No  H  27. Manner of Death 1  Accident investigation	28a. Date of Inju	1 Inpatient 2 E/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)						
=	a Hospital or Attanding 24 hours after death. 5 Funeral Director: After etely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Run City or Town, State)						ural Route Number,	
	To tha Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicel Examin	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.						s stated. e to the cause(s)	
ļ	To tha l within 2. To the I complet		29b. Signature and title of certifier	vlan		29c. Licen			29d. Date signed (Mon.) OVEW bev	(	
	Sta		30. Name and address of person of o co.  Dv. Lawy Hawtun  31. Date filed (Month, Day, Year)	5401 Ola	eath (Item 29a) (Type, Ct. Kol. K ar's Signature	andalls.	foron m	D 2113	3		
	Sta Registr	re	DEC 0 7 2004	Dene	as to	sporks	A. Comment				

State of Maryland / Department of Health and Mental Hygiene 0 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yee **Physician** Joseph Paul Sassani Рм December 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1216 Berkwood Rd Baltimore Rosedale 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1/26/1921 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F 212-20-3558 Director 83 PA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 la marked other than "natural", or Items 23e or 28e-f ahow other treumetic event, Ire Medical Examinar must be notified at MD Director Baltimore 1 ☐ Yes 2 🛣 No Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1216 Berkwood Rd 21237 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 la marked other than any injury or other treumetic event, Ire Meangones. Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 Steel Pipe Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pasqualina Rosario Sassani Tucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine C. Sassani/Wife 1216 Berkwood Rd Rosedale MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5X Other (Specific entombrent Gardens of Faith Mem 12-6-2004 Rosedale MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature Funeral Service Insee 1211 Chesaco Ave Balto MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Box 68760 Physiclan/Medical attending p IF FEMALE. use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2[] No 1 Yes 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Anatural 2 Accident 28a. Date of Injury (Month, Day Year, 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide in 24 hours.
the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and Jitt of certifier 29d. Date signed (Month, Day, Year) D53462 MD of person who completed cause of death (Item 23a) (Type, Print) OAKWOOD ROAD Glen Burnie, MD 21061 عنطو 7845 eseantim MD 31. Date filed (Month, Day, 32 Registrar's Signature State DEC 0 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 6 ALBERTA KATHERINE SACHA 2004 3:45 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death RIVERVIEW NURSING CENTER **ESSEX** BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 Month Day, Year) 1 2 3 2 2 **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🛣 215183809 82 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits Director MD BALTIMORE 1 ☐ Yes 2 🛣 No MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 RODEO CIRCLE 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 1 any injury or other traumatic event, the Magnitus of other traumatic event, the Magnitus or other traumatic event, the Magnitus or other traumatic event, the Magnitus event e Elementary/Secondary (0-12) 1 2 College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JAMES** CVACH ANNA PAZOUREK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWIN J. SACHA / HUSBAND 117 RODEO CIRCLE BALTIMORE, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State December 10 BALTIMORE, MD HOLY REDEEMER ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME CHESACO AVENUE BALTIMORE, MD 21237 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 2- are /Medical Due to (or as a consequence of) Examiner un-Known Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month 5 Other (specify) P.O. I 1 ☐ Yes 2 1 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 (\$\text{\$\text{\$U\tau}\text{\$k}}\$nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tyes 2 1 No or Attending Physician: : After this certifical funeral director, i 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Vivrsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. EASTERN BLUD, M.D-21221. WASBEM. 31. Date filed (Month, Day, Year)

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Registrar

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	th the	Director	10e. Street and Number	7002			ip Coda	uge		10g. Citizen of	What Cour	itry?	
	ath wi	rai	525 Glenburn Av	enue			21613	3			USA		
	er de:	nue	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Dec If Yes, sp	edent of Hi ecify Cuba	ispanic Origin n, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	0- 14. Rad Blad	ce - Americ ck, White,		
336	urs aft	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 XYes 2 □ N If Yes, Give Year or Dates:	10 1 0/1/1-116	1 ☐ Yes	2 🔀 No	Specify:		Specif	w. Whi	te	
21215-0036	within 72 hours after death with the Maryland ane. then "naturel", or items 23a or 28a-f show to Medical Evantinet must be notified at	ted	15. Decedent's Edu	cation		a. Decedent's Us	ual Occupa	ation		16b. Kind of B			
21	ithin 7	Completed	(Specify only highest grad	College (1-4or 5	+)	(Give kind of v life. DO NOT	use retired	luring most of ")	t working				
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anc	d be findal Property of the findal Property o	Be	17. Father's Name (First, Middle, Last)  Edward P. Shaffe:	r					Name (First, Middle		10)		
Maryland	2 should be filled withir and Mental Hygiene. Is marked other then eumetic event, IT. PM.	L C	19a. Informant's Name/Relationship (7)		19	b. Mailing Addre	ss (Street a		n L. Jone		State. Zin	Code)	
	and 2 salth a n 27 le		Kenneth R. Shaffer	:/Son					Millsbor			,	
ore	of Health of Health fitem 27		20a. Method of Disposition  1  Burial 2 Deremation 3  F	Computal from State	20b. Place	of Disposition (Nery, crematory of	ame of		Date	20c. Location -		wn, State	
Ĕ	Pag ment ent; I		'4 Donation 5 Other (Specify)		Metro	Cremato	ry, I	nc. 12	2/6/04	Baltim	ore.	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deptriment of Health and Mental Hygiene. Importent: If item 27 le marked other then "naturel", or items 23a or 28a-f show any injury or other treumetic event, the Medical Eventine rivest Le notified an once.		21. Signature of Funeral Service Licens  Edward A. Greg	ee≤ orchik		22. Name Crema 299 I	and Address tion reder	s of Facility Societ	cy of MD,	Inc.	2122	8	
	Physician /Medical Examiner		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the remainder of the shock, or heart failure. List only one cause on each line.  25. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228  26. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228  27. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228  28. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228										
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ion	death. ctor; After y the funer	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury M		? ′es 2 □ No					
Division	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (S City or Tox	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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	To the within To the Comp	M	29b. Signature and title of certifier				c. License			29d. Date signed		Pay, Year)	
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	10		30. Name and didress of person who co	mpleted cause of de	ath (Item 23a)	(Type, Print)	,		1 /1-	6-1		20	
17-1	Sta	to	31. Date filed (Month, Day, Year)	10/1/150 32 Registra	/ / / / / / / r's Signature	UBro	mbi	ie S	73 + Cam	Dridg	e 11	1613	
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			1. Decedent's Name (First, Middle, Last,	2. Date of Death				n	-	3. Time of Death			
	Physici /Media		Edith S. Simpkins				Decembe.	Day	2004	6:10 P <sup>M</sup>			
	Examir		4a. Facility Name (If not institution, give			4b. City, Tov	wn, or Location	n of Death	Decembe	1	unty of Death		
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	Funeral		Social Security Number     6. Security Number			If Under 1 Y		er 24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign intry)	
	Director		220-12-0920	<sup>3 M 2</sup> <b>X</b> F 92	Yrs.	WOTHING D	ays Hours	7	MAR 21,	1912	2 Ma	ryland	
	and *		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	cation						10d. Inside City Limits	
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	with Ba or	0	2300 Dulaney	Valley Road			1093			g. Cilizen		•	
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ထ	after of		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	'		_		cify Yes or No- Rican, etc.)		Black, White,	etc.	
ğ	ral', o	ğ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🖸	No Specif	'y:		Sp	ecity: Wh	ite	
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Maryland	1 and 2 sl Health and em 27 ls r ther traur		19a. Informant's Name/Relationship (Ty						Route Number,				
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<u></u>	ages nt of t: If it		1 ☐ Burial 2 【文 Cremation 3 ☐ R	Removal from State	cemetery, cren	natory or other	place)		1.				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Madical Examinat must be nufficed at ODGE.		'4 ☐ Donation '5 ☐ Other (Specify)  21. Signature of Funeral Service License		ro Cre						imore,	MD	
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23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy									1	23d. Date of delivery  Month Day Year			
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σ.	that the	P.	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause	a diven in Part	,	23e. Did toba	cco use c	ontribute to th	ne cause of death?	
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The late of the decrease of the decrease of the late of the la							autopsy	psy prior to completion of cause of					
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ō	ig Phya ter this neral di	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at 2			ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
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	lospital hours a uneral [		29a. Certifier 1 Certifying Physics (Check only 2 Medical Examin	isian: To the best of my kno	wledge, death	occurred at the	e time, date a	nd place, ar	nd due to the cau	se(s) and	manner as st	ated.	
	To the Hos within 24 h To the Fun completely	ledical		and manner stated.	and/or inv	estigation, in it	iy opinion, dea	ain occurre	at the time, date	and plac	e, and due to	the cause(s)	
	To To	Σ	29b. Signature and title of certifier	)		29c. Lic	en <i>s</i> e number	dens	290	29d. Date signed (Month, Day, Year)			
1	16			1'D	437	21		12	16/	04			
	K		30. Name and address of person who con										
	-0.		DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year)		VEY VAL	LEY RD.	. TIMO	ONIUM,	MD 2109	93			
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DECEMBER 4, 2004 6:10 p.m.

EDITH SIMPKINS

			T ≈ For Stete Registrer	State of	of Maryland	/ Depa	artment of F	lealth a Death	ınd M		gier 20	04	38681
	Physici	an	Decedent's Name (First, Midd		G1 177					2. Date of Dea	ith	Year	3. Time of Death
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			Doctor's Com	munity Ho	spital			Carro		n			eorge's
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 <b>XX</b>	7. Age (In yrs. las 96		If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day Feb 14	Year)	9. Birth	place (State or Foreign intry)
	Director		(Unk) Usual Residence of Decedent	IL M ZAKE	90	Yrs.		1.007.0		Feb. I4	, 1908	3	(Unkr
land	WOW		10a. State 10b. County	/	10c. City, 1	Town or Lo	cation					1	10d. Inside City Limits
Man	B-f st	tor	Maryland Princ	e George'	S		Mitchel	lvill	e			!	1 ☐ Yes 2 ☐ No
ith the	or 28	Oire	10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Cou	intry?
ath w	8 238 ust t	rail	10450 Lottsfo					2072			Unite	d Sta	tes
U KIKIS-UUSO filed within 72 hours after death with the Maryland	if Health and Mental Hygiene. Item 27 Is marked other then "nature!", or Items 23a or 28a-f show other traumatic event. The Medical Examination is buildliked at	by Funeral Directo	11. Marital Status  1 Never Married 2 Mai	ried 1 Tes If Yes, Gi	2□No (UIII) ve		Vas Decedent of H i Yes, specify Cuba ☐ Yes 2[X] No	ispanic Orig in, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)	14. R. Bl	ace - Amen lack, White	
hours	ture!	ed b	3 XWidowed 4 ☐ Divorced	Year or E		I6a Docad	ent's Usual Occupa	ation					
<b>C</b> 1	n na Medic	Completed	(Specify only highe	st grade completed)		(Give :	kind of work done o OO NOT use retired	ation during most ()	of workin	g	16b. Kind of	Business/Ir	ndustry
d with	giene pr the	Com	Elementary/Secondary (0-12) (Unknown)	College ( (Unknow				(IIn:	avai	lable)			(Unavailabl
<b>5</b>	nd Mental Hygiene. marked other then imatic event, the Me	Bec	17. Father's Name (First, Middle,							(First, Middle,	Maiden Suma		Condvariabl
should be	Ment arked atic	<sup>2</sup>	(Unavailable)							able)			
0 0	h and 7 Is ma Iraum		19a. Informant's Name/Relation: Margaret Wiggl	ship <i>(Type, Print)</i> Granddai	ghter		g Address (Street a				, City or Tow	n, State, Zip	o Code)
1 and	Health tem 27		20a. Method of Disposition	esworth /	20b. Plac	e of Dispos	onument i			am, MA	01984 20c. Location	. City or T	our State
5 %	ant of it: If it y or o		1 ☐ Burial 2 🛣 Cremation  4 ☐ Donation 5 ☐ Other (5		State cem	etery, crem	atory or other place	1				-	
permit. P	두푸루		21. Signature of Funeral Service		Ches		e Cremato		12/1		Belts	ville	, MD
ă	Important in successions		Stylut dol	mann	M00382	Ra	Name and Addres pp Funera 3 Gist Av	al and	l Cre	mation	Servi	ces 209	210
	<b>-</b>		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that of	aused the death. I	Do not ente	er the mode of dying	g, such as c	ardiac or	respiratory arr	est,	20:	Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition	P	neun	m	101						Onset and Death
	Medical aminer		resulting in death)	Due to	for as a consequen	ce of).		. ^		1 ~			4495
		0	Sequentially list conditions, if any, leading to immediate	"7-17 b	entens (or as a consequen	ce of):	Condio	Vasi	cuf	an D	secu	x	Jeans
petr	ansit	Examiner	Cause (Disease or injury	<	(0. 20 2 0000400)	00 017.							
өхөс	an an rial-tra		that initiated events resulting in death) Last	Due to	(or as a consequen	ce of):							
cate be executed	physician and the burial-transit	dicai		d									
	ding pl	(D)	IF FEMALE:										
The faw requires that the death certif	attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregnancy pirth 2 Tetal de- nant at time of death	ath 3 🗆	Ectopic pregnancy					ate of delive	Day Year
j eg	ed by the a	ysic	1  Yes 2 X No 9  Unknown	9 Unkn		5 🗆	Other (specify)						,
s that	igned b	by Pr	Part II. Other significant conditi	ons contributing to d	eath but not resultin	g in the un	derlying cause give	n in Part I.		23e. Did tob	acco use cor	ntribute to th	ne cause of death?
duire	been sig should be		Chronic 1	renal	Dise	ase				1 🗀 Y€	s 2 No	3 🗆 Prob	eably 4 Unknown
a v C	2 5	ompieted								24a. Was a		Were auto	psy findings available
		Com					_			autops perform	V	prior to condeath? 1 Yes	mpletion of cause of
cien:	nis certificate director, pag	Be (	25. Was case referred to medica examiner?					26. Place o	of Death	Check only on			20110
hysi	this al dii	L L	1 ☐ Yes 25 No		npatient 2 ER/			4 U Nurs		e 5 ☐ Reside			y)
ding	fter	tion	27. Manner of Death	9	th, Day Year)	b. Time of Injury	28c. Injury Work	?		ld. Describe ho	w injury occu	rred	
Atten	deat ctor: y the	ertification	2 Accident investi 3 Suicide 6 Could	not be	of Injury - At home,	farm, stre		′es 2 □ No		If. Location (St	eet and Num	her or Rum	l Route Number,
Ö	s after	Certi	4 Homicide	buildi	ng, etc. (Specify)	,	,,,			City or Town	, State)	50, 0, 115,0	r riodia redinoer,
To the Hospitel or Attending Physicien:	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)  1 Certifyir 2 Medicel	ng Physician: To the Exeminer: On the band mani	best of my knowled asis of examination ner stated.	dge, death and/or inve	occurred at the time estigation, in my op	e, date and inion, death	place, an	d due to the ca	use(s) and m ite and place,	anner as st and due to	ated. the cause(s)
To th	To the comp	Me	29b. Signature and title of certifie				29c. License				d. Date signe	ed (Month, I	Day, Year)
	j.		r Ka Kush	~ anoi	19 N	1)	D	201	08	3	11/	29/	04
	V		30. Name and address of person				,						
	Sta	io	Rakesh Arora 31. Date filed (Month, Day, Year)		4300 Gall egistrar's Signatyre			Bowi	e, M	207	15		
	Registra	_	DEC 0 7 200	1 Senes	me B	Sign	rocker						

			For State Registrer	State of	Maryland	/ Depa	rtment of F	lealth a <i>Death</i>	and M		giene Reg. No.		38	682
	Physici		1. Decedent's Name (First, Middle, I Peter V. Serr	•						2. Date of Dea Month December	ath		3. Tir	me of Death
	/Medic Examin		4a. Facility Name (If not institution, g		ber)		4b. City, Town, o				4c.	County of De	eath	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			Casey House  5. Social Security Number 6	. Sex 7	7. Age (In yrs. las	t birthday)	Rockvil If Under 1 Year		24 Hrs.	8. Date of Birtl	_	ntgome		tate or Foreign
	Funeral Director		184-20-8022	1 <b>X</b> M 2□F	74	Yrs.	Months Days	Hours	Min.	Dec. 30	/, Year)		Country)	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Lo	cation						10d Inci	de City Limits
	Maryl -f sho	ţŏ	Maryland Montgo	m 0 3417										Yes 2 X No
	h the	Director	10e. Street and Number	шегу	PITA	er Sp	10f. Zip Code				10g. Citi	zen of What	Country?	
	23a c	alD	10417 Haywood Dr	ive			20902			Ţ	JSA			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23s or 28s-f show any njury or othar traumatic evant, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 ☐ Never Married ② Married	Armed Ford		13. V	Vas Decedent of F Yes, specify Cub	lispanic Ori an, Mexicar	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wi		ın,
Maryland 21215-0036	ursafi al', or Exami	by	3 ☐ Widowed 4 ☐ Divorced	WV-a Cina	teli947-49	1	☐ Yes 2【X No	Specify:				Specify: Wh	ite	
5	72 ho 'natur	Completed	15. Decedent's (Specify only highest of		1	6a. Deced	ent's Usual Occup	ation during mos	t of workin	a		nd of Busines		
121	within 3ne. than "	ldu	Elementary/Secondary (0-12)	College (1-		life. L	OO NOT use retire	d)			<b>1</b> :1 . 1	1 0		
d 2	filed Hygie Sthar ant, I	e Co	12 17. Father's Name (First, Middle, La	st)		Recor	ds Manag		er's Name	(First, Middle,		eral G Sumame)	overn	nent
<u>a</u>	uld be Aental rked (	To Be	Peter V. Serra S	r.					y God					
lar)	2 sho and h is ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Numbe	or or Rural	Route Numbe	r, City o	r Town, State	, Zip Code)	
	1 and Health em 27 ther t		Dolores A. Serra 20a. Method of Disposition	/wife	20h Plac	10417	Haywood							
μÖ	ages anf of I it: if it: y or o		1 ☐ Burial 2X Cremation 3  4 ☐ Donation 5 ☐ Other (Special	☐Removal from St	tate cem	etery, crem	latory or other place  Cremate	,	Jecem 200	<del>B</del> er 6,		ton, M		
Baltimore,	permit. F Deportme Importan any njur		21. Signature of Funeral Service Lic		14		Name and Addre			-				
<u> </u>	P P P P P		Devely L	Hernit	6 MO12		verly L.							
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. <u>Renal</u>	ch line. Failure		r the mode of dyir	ng, such as	cardiac or	respiratory arr	rest,		Approx Interva Onset	kimate Il Between and Death
	Examiner			1	r as a consequen								10.70	F -5000
		ner	Sequentially list conditions, if any, leading to immediate cause. Entire University Cause (Disease or injury		a e Rena ras a consequen		sease						3 1/2	years
1.	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c Renal		ase						30 ує	ars
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE	,	D0 10 (0)	as a consequen	ice oi):								
9	ifficate g phy: as the	ledical		0.										
Box	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Petal de		Ectopic pregnancy	,			2	3d. Date of d		
0.	the at	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of death		Other (specify)					Month	Day	Year
عذ	w requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions	contributing to dea	ath but not resultin	ng in the un	derlying cause giv	en in Part I.		23e. Did to	bacco u	se contribute	to the cause	of death?
<b>Records</b> ,	en sign	ed by	Renal Dialysis;	Aortic Va	lve Rep	lacem	ent;			1 🗆 Y	es 2[	INo XXI	Probably 4	□Unknown
င္ပ	taw reas bee	Completed	Cardiomyopathy							24a. Was a		24b. Were a	autopsy finds	ngs available
E E		Соп								perfori	med? 2 <b>X</b> No	death?	s 2 No	or cause or
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Oth			Check onl on				
Ö	g Phys er this eral di	n: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of	Injury 28	b. Time of	28c. Injur	v at		e 5 🗆 Reside 3d. Describe he			ecify) hos	pice
Ö	anding vafh. or: Afte	atlo	1 X Natural 5 ☐ Pending investigati	ion	, Day Year)	Injury	M 1	k? Yes 2 □ i	No					
DIVISION OF	al or Attanding P s after death. I Diractor: After t d in by the funera	Certification:	3 Suicide 6 Could not determine	ad 286. Place of	f Injury - At home g, etc. <i>(Specify)</i>	, farm, stre	et, factory, office		28	3f. Location (SI City or Town	treet and n, State)	Number or F	Rural Route I	Vumber,
	Hospital or Attanding Physician: 44 hours after deafh. Funaral Diractor: After this certific tely filled in by the funeral director.		29a. Certifier TXXCertifying F	Physician: To the b	est of my knowle	dae death	occurred at the 41-	ne date an	d place, as	nd due to the =	alico(c)	and manner	as stated	
	To the Hospital within 24 hours a To the Funaral to completely filled	Medical	(Check only 2 Medical Extone)	eminer: On the bas and manne	is of examination	and/or inv	estigation, in my o	pinion, deat	th occurred	d at the time, d	ate and	place, and du	is stated. ie to the cau	se(s)
	To the within 2 To tha complet	Ž	29b. Signature and title of certifier	01	,		29c. Licens	e number		2	9d. Date	signed (Mor	nth, Day, Yea	ar)
			1	· 2	be	71	D094	70		D	ece:	mber 5	, 2004	ł
	20		30. Name and address of person wh					T7 -	·	36	1	-1 000	0.5	
	Sta	e	Eugene P. Libre 1 31. Date filed (Math Can Year) 2[	M.D. 1040	gistrar's Signature		· •		ingt	on, Mar	ута	na 2089	95	
	Registra	ar	DEC 07 2	JU4 3º	marie !	Ø	sports	1						

			1- State of Maryland / Department of Health and Mental Hygierne Certificate of Death  State Registrar		38683						
	Physicia		1. Decedent's Name (First, Middle, Last) Edwin Deronda Samuel  2. Date of Death Month Day December 6		3. Time of Death 0 8 45 A M						
	/Medic Examin			County of Death							
	Funeral Director		5. Social Security Number 223-54-0808 6. Sex 1 M 2 F 61 Yrs. 7. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 1	9. Birthp Coun 13 Vir	lace (State or Foreign try) ginia						
	land		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	1	0d. Inside City Limits						
	e Many te-f sh	ctor	Maryland Baltimore Lansdowne		1 ☐ Yes 2 ☑ No						
	ith with th 23a or 26 ust be no	ral Dire	10e. Street and Number 2741 Yarnall Road 10f. Zip Code 21227	tizen of What Coun USA							
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, if a Madicial Erric is at most ke rodified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Marned  1 Never Married 2 Marned  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 No If Yes, Sive Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americ Black, White, Specify:							
21215-0036	vithin 72 ho ne. han "natur s Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  R  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Painter	Gind of Business/Ind							
land 2	12 should be filed within h and Mental Hygiene. 7 le marked other than "Ireumetic event, the Mer	To Be Co	17. Father's Name (First, Middle, Last) Samuel Edwin Samuel  18. Mother's Name (First, Middle, Maiden  Mattic Coldio Pa	Sumame)	,						
, Maryland	and 2 shou alth and M 27 la mar er treumet		19a. Informant's Name/Relationship (Type, Print)  Juanita . Scallio (wife)  19b. Mailing Address (Street and Number or Rural Route Number, City of 2741 Yarnall Road, Lansdowne, Mo								
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tre		1 (A Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 12/9/04 Bal	ocation - City or To							
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home 237 E. Patapsco Ave., Balto.,	P.A. 21	225-1856						
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death  MONENS						
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Metastatic Cavcinoma  Due to (or as a consequence of):		TOTOVENS						
	<u> </u>	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  b. (AYCINOMA OF LIVEY  Due to (or as a consequence of):  (YV) (CICOMA)								
68760,	eath certificate be executed attending physicien and for use as the burial-transit	edical Examiner	resulting in death) Last  Due to (or as a consequence of):								
P.O. Box 68	ne death certif the attending hed for use a:	Physician/Medi		23d. Date of delive Month	ry Day Year						
	quires that the signed by all be detacted	by	Part II. Other significant containing to death out not resulting in the underlying cause given in Part I.	use contribute to th	e cause of death?						
Records,	The law requir ate has been si page 2 should	Completed	24a. Was an autopsy performed? 1 □ Yes 2 ₺ No	prior to cor death?	osy findings available inpletion of cause of						
of Vital	Physician: The rthis certificate hirral director, page	Be	25. Was case referred to medical examiner?  26. Place of Death (Check only one)								
	Ph rale	atlon: To	To the 2 Sk No. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								
Division	al or Atter s after dea il Director id in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Reconstruction of the street of the str								
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical (	29a. Certifier (Check only one)  29a Certifier (Check only one	d place, and due to	the cause(s)						
	To t To 1	Σ		ate signed (Month,	Day, Year)						
1	$\Omega$		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ember 1	5,2004						
	4		Naveen Pesala 900 (aton Avenue, baltimove,	MD 21	229.						
0	Sta Registi		A A A A A A A A A A A A A A A A A A A								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 38684 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC. **Physician** 2 2004 SANDLER MELVIN Н 7:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year Months Days If Under 24 Hrs. 6. Sex 10 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours Director 218-16-1484 09/09/1923 MD Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Medical Examiner must be notified at MD BALTIMORE 1 ☐ Yes 2 ☐ No BALTIMORE Directo 10e. Street and Number 10g. Citizen of Whal Country? 10f. Zip Code 7 SLADE AVENUE APT. #417 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW I I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ٥ 1 Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other traumatic avant, the CHEMIST INDUSTRIAL COATING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ( 12 should be fi and Mental H Is marked otl permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or othar traumatic av 2002. SANDLER REUBEN BERTHA MERMELSTEIN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 SLADE AVENUE APT. #417 BALTIMORE, MD 21208 SHIRLEY SANDLER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State OHEB SHALOM MEMORIAL 12/05/2004 REISTERSTOWN, MD 4 □ Donation = 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fyseral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter th failure. shock, or hea Immediate Cause (Final disease or condition resulting in death) **Physician** Metasphi CAUCUS months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 2/3 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Cother (Specify) Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 2 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Watural 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Yes 2 No 2 Accident after death in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To tha Hospital within 24 hours a To tha Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

cember

State Registrar 29b. Signalure and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMPURS MD 32. Registrar's Signature 2004

6601 N. Charles Street

29c. License number

29d. Date signed (Month, Day, Year) December 3

Baltimore, MD.

21204

				partment of Health and N ertificate of Death		ena 004	38685
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Ursula R. Tulio		December		9:05 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
			Greater Baltimore Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Towson  If Under 1 Year   If Under 24 Hrs.	9. Date of Righ	Baltimo	re
	Funeral Director		105-28-6805 1 M 2X F 83 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, ) July 26,	1921 Ge	rmany
			Usual Residence of Decedent				
	arylan show	_	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits 1 ☐ Yes 2 XNo
	vith the Marylar or 28e-f show be notified at	Director	Maryland Baltimore	Baltimore	10.	g. Citizen of What C	
	with t		10e. Street and Number	10f. Zip Code 21207	100	U.S.A.	ountry :
	Jeath w	Funerai	1825 Woodlawn Drive Suite 106  11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
, 9	after dea	표	1 Never Married 2 Married 1 ☐ Yes 2X☐ No		Rican, etc.)	Black, Wh	·
93	ours a	d by	3 ☐ Widowed 4 ∑noivorced If Yes, Give Year or Dates:	1 ☐ Yes 2(X.No Specify:		Specify: Wh	ite
<u> </u>	s within 72 hours after death with the Maryland liene. rthan "netural", or Itams 23a or 28e-f show the Medical Examination of must be notified at	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	king 16	6b. Kind of Busines	s/Industry
12	withir ene. than	duc	Elementary/Secondary (0-12) College (1-4or 5+)	1 Service	1	U.S. Gove	rnment
<u>0</u>	be filed withintal Hygiene.	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
la la	Ind be fental rked o	To B	Unknown		Unknown	1	
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg itam 27 is marked otha other traumatic event,		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Rur	ral Route Number, (	City or Town, State,	Zip Code)
	ss 1 and 2 of Health a itam 27 i		Darlene Davies/Lawyer-Guardian 1825				1207
Baltimore,	Pages 1 nent of H int: If itan	l i	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place)		Oc. Location - City o	r Town, State
ti Ti	t. Partmen tant:			y Cemetery 12/8/	/04 B	altimore,	Maryland
Bal	permit. Pages Department of Important: If ite any injury or of once.		21. Signature of Funeral Service Licensee  Muchael Pharquelo- 6	22. Name and Address of Facility Mar 009 Harford Road Ba	zullo Fu altimore,	n <b>er</b> al Cha Maryland	pel P.A. 21214
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician	6 0	Immediate Cause (Final disease or condition resulting in death)	Rivatory 1-a	ilere	alive	Days
	/Medical Examiner		Due to (or as a consequence of):	Rivatory Few		0	
		e e	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	ic ousmichio	2 pu	MENEN	7
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
o,	an an		resulting in death) Last Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transi	dicai	d				
9	entifica ling pl	Mec	IF FEMALE:				1
Вох	leath certific attending p	Physician/Me	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of d Month	elivery Day Year
P.O.	that the de ed by the a detached	ıysic	1 ☐ Yes 2 🖼 No 9 ☐ Unknown 9 ☐ Unknown	JEJ Other (Specify)			
م	that the hed by detac	by Ph	Part II, Other significant conditions contributing to death but not resulting in th	underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	quires in sign uld be	d be			1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
00	aw requir as been s 2 should	ompieted			24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
R	The tate happage	E O			performe	ed? death?	a./
Division of Vital Records,	sician: The certificate har rector, page	Be C	25. Was case referred to medical examiner?		th (Check only one)	)	
7 \	Physic this co	၉	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatient 2 X ER/Outpa			ice 6 Other (Sp	ecify)
o uc	ding F h. After funera	ion	27. Manner of Death  1 Matural 5 ☐ Pending (Month, Day Year)  1 Matural 5 ☐ Pending (Month, Day Year)		28d. Describe how	v injury occurred	
isic	Attendi death. ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (Stre	eet and Number or F	Rural Route Number,
Ο̈́	after after Dira	Certification:	4 Homicide determined building, etc. (Specify)	,,	City or Town,	State)	
	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funarel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, d 2 Medical Examine: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau rred at the time, dat	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
_	Fo the	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Moi	nth, Day, Year)
	1		1/1/Con ladi on	D-00128	49	12-2	-04
	5		30. Name and address of person who completed cause of death (Item 23a) (Ty)  A'A' (3414 ADI MD. 7600		Touse	on Mi	21204
1	Sta Registi	-	31. Date filed (Montage Park 2004 32. Registrar's Signature	Spark			

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of L	ealth and M Death		giene () (	38686
П	Dhusisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th Day	Year 3. Time of Death
,	Physicia /Medic		Clarence		<u> </u>				19 3	2004 332 M
3	Examin	er	4a. Facility Name (If not institution, git Lorient Frankfo			4b. City, Town, or	Location of Death		4c. County	or Death
	Funeral				last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	( Voas)	Birthplace (State or Foreign Country)
	Director		216-20-5564	1 ☐ M 2 ☐ F 7	8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 4 – 18 – 2	6	MD
	and .		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary -1 sho fied a	ţō	MD	Ва	ltimo	re				12 Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?
	ath wi		201 N. Washing			21231			JSA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at once.	by Funerai	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 █️XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - American Indian, ck, White, etc. :: Black
21215-0036	"natur	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of work	ing	16b. Kind of Bu	usiness/Industry
72	withir iene. than	omo	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	Labo		,		Genera	al
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<u>     </u>	Menta	ToE	Samuel Taylor				Bessie			
Maryland	12 sh h and 7 Is m traum	1. 11	19a. Informant's Name/Relationship	•		ng Address <i>(Street a</i> N. Washi				
ē,	Healt Healt tem 2		Amy Ward (sist 20a. Method of Disposition		Place of Dispo	sition (Name of		Date		City or Town, State
Ē	Pages nent of nt: If i		12 Burial 2 ☐ Cremation 3 ( `4 ☐ Donation 5 ☐ Other (Spec	Removal from State	. Car	matory or other place me1		30-04	Dunda]	Lk, MD
Baltimore,	permit. Departm Imports any inju		21. Signature of Funeral Service Lice		22	2. Name and Addres				
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	inplications that caused the dear						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pros	tate	Can	cer			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c						
8760,	rcate be executed physician and the burial-transit	ai Ex	resulting in death) Last	Due to (or as a conse	quence of):					
587		edicai		d						
.O. Box (	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3[	Ectopic pregnancy Other (specify)				te of delivery onth Day Year
<u>α</u>	quires that I n signed by uld be deta	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			ribute to the cause of death? 3 ☐ Probably 4 ∰Unknown
Vital Records,	. The law requir cate has been si page 2 should l	Completed						24a. Was a autop perfor	med?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
/ita	Attending Physician: Th r death. sctor: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		other actions Other	26. Place of Deat			
5	Physic rthis ral dir	٠.	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time o	IL 3LI DOA	4 mg (vuising m	ome 5 Resid		
o	nding Phy th. :: After thi e funeral o	tion	1. □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	Work	k? Yes 2 □ No			
Division	al or Atter after des Director d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury · At I building, etc. (Spec	nome, farm, str ify)	reet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	per or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical C		hysician: To the best of my kn miner: On the basis of examin and manner stated.						
	To th withir To th comp	M	29b. Signature and title of certifier			29c. License	e number		29d. Date signe	d (Month, Day, Year)
)			16:1			リム	3725		11/2	29/04
			30. Name and address of person who	0 / 10.	m 23a) (Type,	Print)	Neel	nel "	Balfin	21221 nege
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis ar's Sign	ature	1				
	Registi	ar	DEC 0	7 2004 Store	15	Gara)				

State of Maryland / Department of Health and Mental Hygiene 1 38687 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year  $\frac{Month}{11}/20/04$ **Physician** SHIELA 7:30pm/Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** BALTIMORE MILLENNIUM FRANKLIN SQ. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 7/12/4 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2√2F Yrs. MD. 7522 61 219 40 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State or 28e-f show treumatic event, the Medical Examiner must be notified at 1 TyYes 2 □ No BALTIMORE Director MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1120 STODDARD CT. 21201 238 death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. or Items 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked ot DEMPSEY ALONZO LYNN LIZZIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4805 WESTPARK WAY BALTO. MD. 21209 WILLIAM THOMAS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ŏ permit. Page Department of Important: If any injury or once. NEW CATHEDERAL 11/27/04 BALTO. MD. 22. Name and Address of Facility
ESTEP BROS
1300 EUTAW I 21. Signature of Funeral Service Licensee FUNERAL HOPL. BALTO. HOME P1A 17 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Examiner RACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by BROVASCULAR 1 Yes 2 No 3 Probably 4 Schrknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No 1 TYes 2 10 No the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Vursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á within 24 hours after or to the Funerel Directornoletely filled in brownletely filled in 4 - Homicide \*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OO AR MURYPLACE BAL, MOZIZOI

DHMH 17 Rev 1/2001

State

Registrar

CVM.D.

\$2. Registrar's Signature

abhak

31. Date filed (Month, Day, Year)

DEC 07 2004

State of Maryland / Department of Health and Mental Hygie 38688 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 3, **Physician** Erma Tucker Gay 2004 9:55 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner 8263 Woods Road Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F Months 75 NOV 26, Director 213-28-8280 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural" ~ " any injury or other treumatic even." 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Millersville Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21108 USA 8263 Woods Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNK. School Cafeteria Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isaac Monroe Whitaker Agnes Una Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Dean/Sister 8263 Woods Road Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ' 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 12/4/04 Baltimore, MD 21. Signature of Funeral Service Greensee

Edward A. Gregorchik 22. Name and Address of Facility Cremation Society of MD, Inc. 1299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SQUAMONI CELL CARCINOMA nonte /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ပ this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) MO 2,55506 December 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12, tel 32. Registrar's Signature ter Eren 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygie 2004 38689 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Isabelle Mary Williams December 4, 2004 12:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9532 Bauer Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Nov. 16, 1 Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 【XF 86 7918 Yrs. Maryland 218-03-4465 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itama 23a or 28a-f show or other traumatic evant, the Medical Examiner must be notified at 1 Tyes 2 No Director Maryland Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21236 9532 Bauer Avenue U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 □ Divorced 'naturai', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatin Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Accounting Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Swope Maru Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Philpot (daughter) 2826 Cross Country Ct., Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Zion Ch. Cem. 12/7/2004 Bel Air, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any learning transcriber of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examine requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 N Residence 6 Other (Specify) P funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.
narai Diractor: A
filled in by the fu death. 2 ☐ Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours at To the Funarai D 1 [[Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. CHARLES ST. BALTIMORE, 171 21204 GEORGE A. BEDON 171) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygie ( )

Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death December 1, 2004 **Physician** 8:10 а м Virginia Davern Weaver /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford 1308 Stockton Road Joppa If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) June 18, 1923 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Yrs 218-18-9833 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 la marked other than "natural", or items 23s or 28a-f ahow other traumatic event, the Medical Examinat must be notified at Joppa Harford 1 ☐ Yes 2 No Md. Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21085 U.S.A. 1308 Stockton Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years Hygiene. College (1-4or 5+) food service cafeteria worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is 1 and 2 should be fill Health and Mental H tem 27 la marked off Claudia Givings Lynch Charles M. Lynch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 1308 Stockton Road, Joppa, Md. 21085 Pages 1 and 2 ment of Health a ant: If item 27 la ury or other trains Scott Weaver/son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 12/4/04 Bayview Crematory Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Perforated duodinal Pnysician month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760 by Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2019-No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ů 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Injury Division To the Hospital or Attending 1 5 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier D34652 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rel Air Mary land Nort h SCOLF 32. Registrar's Signature 31. Date filed (Month State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registra 38691 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year November 28, 2004 **Physician** Gladys Marie Whitehead 10:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Mariner Healthcare of Laurel Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. June 26 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M XXF Vrc 86 217-20-7036 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 🏋 No Howard Laurel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and he 10434 Shady Acres Lane Completed by Funeral 20723 death USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married ŏ 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 Nidowed 4 Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. the Mo Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) as 1 end 2 should be fit of Health and Mental Hittem 27 is marked oth Be ٩ Charles Edward Poe Pages 1 end 2 should Myrtle Kathryn Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Whitehead, Jr./Son 1720 East Deep Run Road, Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. ¹XXBurial 2 ☐ Cremation 3 ☐ Removal from State **EmmanuelCemetery** 12/3/2004 Scaggsville, MD \*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD M00770 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's, End Stage resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examiner Due to (or as a consequence of): death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) detached the 9□ Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ed bluods Osteoarthritic 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown peed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No has page 2 1 ☐ Yes 2 ☑ No 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 📉 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ۵ 1 ☐ Yes 21 No 2 ER/Outpatient 3□ DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò

To the Hospitel within 24 hours a To the Funeral D 10

Saltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 07

mace

Andrew Kundrat, M.D. 8317 Cherry Lane 32 Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laurel, Maryland

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

D0036716

29d. Date signed (Month, Day, Year)

20707

November 29, 2004

Donald Wakefield Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 7727State of Maryland / Department of Health and Mental Hygiene (12-8-04 Eas Certificate of Death Reg. No.

1. Decedent's Name (First, Middle, East) 10b PER G 838 12/23/04 JH

2. Date of Death Reg. No. AKG 3. Time of Death Month **Physician Donald Thomas Wakefield** 6:24 P M December 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard Howard If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Min 217-100-733 Yrs. Director May 13, 1952 Washinton, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County treumatic event, the Medical Examiner must be notified at HOWARD 1 ☐ Yes 2√☐ No Director Laurel Prince George Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20723 U.S.A. Items 23a 8328 Cherrybrook Ct death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. In 27 is marked other than "neturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ White 3 Widowed 4 Divorced Year or Dates: Completed . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Computers College (1-4or 5+) Elementary/Secondary (0-12) Computer Salesman /Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 James Wakefield Virginia McGregor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trei once. 8328 Cherrybrook Ct. Laurel, Maryland 20723 \//ife Alon Wakefield 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State All County Cremation Services, inc. 12/07/2004
22. Name and Address of Facility 5 ☐ Other (Specify) <sup>¹</sup> 4 □ Donation Sykesville, Maryland Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 11101243 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carbon Monoxide Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IE FEMALE: 23c. if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 1 🗌 Yes 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy rmeaz 2 XNo 1 Yes 1 Yes Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 🔯 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1√2Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Found, After Hospitel or Attending 1 Natural 5 Pending Subject inhaled carbon monoxide death. 12-1-04 1 ☐ Yes 2 No investigation 2 Accident after death Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 8328 Cherrybrook Ct. To the Hospitel of within 24 hours at To the Funerel D. Laurel, MD Garage of residence 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. December 2, 2004

State Registrar

111 Penn Street, Baltimore, Maryland 21201

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1- For Amend Item 10e per In G838 12-7-04 tas

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month D VOVEMBER **Physician** Ann Belle Wells 28, 2004 4:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sax Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖸 F 218-19-5335 Director 20, 1919 N. Carolina Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at N/A Maryland Baltimore X Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 1125 E. Northern Pari Parkway 21239 USA or items 23a death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after ☐Yes **¾**☐ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ 3 Widowed 4 □ Divorced Year or Dates: 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within perantment of Health and Mental Hygiene. Important: If item 27 is marked other than "1 any injury or other traumatic avent Private Industry Flementary/Secondary (0-12) College (1-4or 5+) Housekeeping 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Ida McCloud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1125 E. Northern Parkway Baltimore, Md21239 Willie A. Wells/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 03/04 1 Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery Pikesville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home - Mtman + HADRIS ROAd SZYU Reig Your 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner PLEURAL EFFUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit CONGESTIVE HEART FAILURE and Due to (or as a consequence of): Box 68760 attending physician certificate be Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown □Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 CEREBROVASCULAR ACCIDENT 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an performe certificate 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 📉 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Diractor: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 124 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20/04 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON POH LIM. OSLER DRIVE. TOWSON, MARYLAND 21204 31. Date filed (Month, Da 32. Registrar's Signature State Registrar

			For State Registrer	State of Maryland	Certificate of Death		2004 00034
	Physici	an	1. Decadent's Name (First, Middle, Last,	14/100	T <sub>c</sub>	2. Date of Death	Day Year
	/Medio	al	4a. Facility Name (If not institution, give,	street and number)	4b. City, Town, or Location		4c. County of Death
1				eneral Hospi	t birthday) If Under 1 Year If Under		A Right less (State or Service
P	Funeral Director		215-78-3058 19	7. Age (In y/s. las (M 2□ F 45	Yrs. Months Days Hours	24 Hrs. 8. Dale of Birth Min. (Month, Day, Ye)	9. Birthplace (State or Foreign Country)
	yland sow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Fown or Location	,	10d. Inside City Limits
	Ba-f sh	ctor	Maryland N/	4 B	paltimore		1 12 Yes 2 □ No
	3e or 2	I Dire	10e. Street and Number	1000	10f. Zip Code	7 10g.	Citizen of What Country?
	tems 2	unera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Ori tf Yes, specify Cuban, Mexican	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-1 show minportant: If item 27 is marked other than "netural", or Items 23e or 28e-1 show pay injury or other treumatic event. The Madical Examinar must be neitlisd at once.	Completed by Funeral Director	Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
21215-0036	in 72 ho "netul	oletec	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	it of working	. Kind of Business/Industry
	filed with Hygiene. other ther	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Street Vena	dor S	elf-Employed
Maryland	ould be fil Mental H arked oth atic even	To Be	17. Father's Name (First, Middle, Last)	me Sc	18. Moth	er's Name (First, Middle, Maid	of Sumame)
lary	2 should and Mer is marke eumatic	-	19a. Informant's Name/Relationship (Ty	po. Print) (Sister)	19b. Mailing Address (Street and Numbri	er or Rural Route Number, Cit	ry or Town, State, Zip Code)
_	1 and Health Iem 27 other tr	. 3	20a. Method of Disposition	Srown 20b. Place	ee of Disposition (Name of letery, crematory or other place)	ane Bat	Location - City or Town, State
Baltimore,	Pages ment of ent: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	NA IA	12/9/2004 7	Balto, Md.
Balt	permit. Page Department Importent: If eny injury o		21. Signature of Funeral Service Licens		22. Name and Address of Fill	stuneral t	tome, 2/2/6
	144		23a. Pan Enter the disease, or complished, or heart billure. List only o	ic in ns that caused the death.	Do not enter the mode of dying, such as		Approximate therval Between
	Physician /Medical	Ų į	Immedine Cause (Final disease or condition resulting in death)	Respirato	ory Failure		Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a consequent	Immun Modet	sciency Sna	home
À	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):		
0,	an and	Exar	that initiated events resulting in death) Last	Due to (or as a consequent	nce of):		
09289	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	edical		Liver	Cirrhosis		
Box (	eath certifi attending I for use as	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de			23d. Date of delivery  Month Day Year
O.	the dea by the at ached fo	Physician/N	1 Yes 2 No	4□Pregnant at time of deat 9□ Unknown	th 5 Other (specify)		World Day real
S, P	w requires that the death cer been signed by the attendir should be detached for use	by P	Part II. Other significant conditions co.	ntributing to death but not resulti	ng in the underlying cause given in Part I		co use contribute to the cause of death?
Records,	w requi	leted				24a. Was an	24b. Were autopsy findings available
I Re		Completed by				autopsy performed	prior to completion of cause of death?  No 1 Yes 2 No
Vital	Physicien: The lithis certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 XInpatient 2 ☐ EF	Other	of Death (Check only one) ursing Home 5  Residence	G TOther (Specific)
n of	ding Phys n. After this funeral dii	on: To	27. Manner of Death		8b. Time of 28c. Injury at Work?	28d. Describe how in	
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At hom	M 1 ☐ Yes 2 ☐ e, farm, street, factory, office	28f. Location (Street	and Number or Rural Route Number,
Ö	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Cert		building, etc. (Specify)	edge, death occurred at the time, date an	City or Town, St	·
	n 24 hc n 24 hc he Fun pletely i	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	n and/or investigation, in my opinion, dea	ath occurred at the time, date	and place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. License number	-4 D 29d.	Date signed (Month, Day, Year)
	6	Į.	30. Notice and address of person who co	ompleted cause of death (Item 2	3a) (Type, Print)		12 0/04
	_	to	31. Date filed (Month, Day Year)	32. Registrar's Signatur	10 Marylan	1 General	Harpida/
**	Sta Registı		DEC 07	2004 Depart	& Sould		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiepen 38695 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 7: 45 p. M IDUDAQUIST DELEMBER 03 2004 Duise /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie North Arundel Hospital Arundel Anne If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F AUG 6, Director Maryland 214-20-6205 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Gambrills Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2258 21054 USA September Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after of death and Mental Hygiene. 8m 27 is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White by 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Ditty Jesse Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 7819 Walnut Tree Road Severn, MD 21144 Sandra M. Quick/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 12/4/04 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Lipensee <sup>22</sup> Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Edward A rance Gregorchik MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE CHRONIC OBSTRUCTIVE PULMONARY MIEMI Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician 68760 be Physician/Medical requires that the death certificate Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9□ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 2 No 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Hospital or Attending Injury 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 03,2004 100 Tra 73 PELEMBEIZ belehe kassahun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11500 4PRING MD 20904 CUPHERLAND HILL WAY SILVER DESSE 32. Registrar's Signature 31. Date filed (Month, Day, Year) oaks Registrar DEC 0 7 2004

Amend item#4a, perHE, 12/14/04 TTG838
State of Maryland / Department of Health and Mental Hygiene 10 14 38696 For State Registrar AMEND ITEM #10e PER FH G838 \$21091040f Theath Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 2004 Year **Physician** December Znamirowski 5:45 P M Margaret Victoria /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie Pamela Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/1/1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 X F 85 CANADA 216-05-9913 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or Iteme 23a or 28a-f ahow Examiner near be notified at 1 Yes 2 No GLEN BURNIE ANNE ARUNDEL Direct 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code PAMELA ROAD 21061 U.S.A. Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2☐No WHITE Specify Specify: 3 ☐ Widowed 4 ☐ Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens Important: If item 27 ie marked other that eny injury or other traumatic event, Inc. ance. SALES RETAIL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOHN PONICKI (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET DICKEN - DAUGHTER 268 LAKE RIVIERA ROAD, PASADENA , MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Conation 5 Cother (Specify) STANISLAUS 12/7/2004 BALTIMORE, MD ture of Funeral Service Licensee 21. Sign 22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. 1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061 MOHAD art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Arterioselerotic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant signed by the attend d be detached for u 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Qunknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 KNO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To s after deam. al Director: After this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 / Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Deputy 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier mo ess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

filed within 72 hours after death with the Maryland

"naturel"

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

ding physician and

certificate

this

or Attending Physician:

To the Hospital within 24 hours a To the Funeral E

11,9m

DEC 07

2004

31. Date filed (Month, Day, Year)

ONES, MD

32. Registrar's Signature

			State of Marylan 24a per Dr., G8	39,86	rtificate of	Death		•	38697
ysicia	an	1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	Day Yea	
Medic	al	Dorothy Foxwell A  4a. Facility Name (If not institution, give			4h City Town o	or Location of Deat		8, 2004	12:30 p <sup>h</sup>
amin	er	Chesapeake Woods				nbridge	''	Dorche	
eral		5. Social Security Number 6. Se	x 7. Age (In yrs. I	ast birthday,	If Under 1 Year	If Under 24 Hrs			irthplace (State or Foreig Country)
or		219-14-4954	M 2 1 81	Yrs.	Months Days	Hours Min.	Jan. 21	, 1923 M	aryland
		Usual Residence of Decedent  10a. State 10b. County	100 Cib	. Town and					
	5			, Town or L					10d. Inside City Limit
	ecto	Maryland Dorches  10e. Street and Number	ter		Cambridge 10f. Zip Code	5		0g. Citizen of What	
	ä	410 Robinson Ave	<b>0</b> 110		216	513	'	US.	
	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.	S. 13.		Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No-		nerican Indian,
	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces?				to Rican, etc.)	Black, W	nite, etc.
	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	<i>M</i> hite
	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup	during most of wo	rking	16b. Kind of Busines	s/Industry
İ	John	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	nd)			
	S	12 17. Father's Name (First, Middle, Last)		A	ssembly V	1	me (First, Middle, I	Electro	onic
	Be	Baldwin W. Foxw	<b>a]]</b>				el Kirwai		
	ပ္	19a. Informant's Name/Relationship (T)		10b Mail	na Address (Street	ļ		r, City or Town, State	Zin Codel
Ì									
		Richard E. Asple:	20b. P	lace of Disp	osition (Name of	-	Cambridge Date	e, MD 216:	or Town, State
		1 D Burial 2 ☐ Cremation 3 ☐ F	RAMOVALIZOM STATA		matory or other pla	ery 11/			
	1	*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service/Licens						Hurlock,	raryland
ouce		My Con Sugar	· Kennin	0003	urran-Bro	mwell Fu	neral Hor ridge, M	me, P.A.	
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the death	n. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory arr	est,	Approximate
n	97 1	Immediate Cause (Final	1	4 4					Interval Between Onset and Death
ı		disease or condition resulting in death)	a <u>demen</u>						syear.
ı									
١	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):					
	Examiner	that initiated events	c						
ı	EX	resulting in death) Last	Due to (or as a consequ	uence of):					
	lical		d						
	Physician/Med	IF FEMALE:							200
	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	death 3	Ectopic pregnanc	'y		23d. Date of d Month	elivery Day Year
	/slc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at time of de 9□ Unknown	eath 5	Other (specify)				,
	Ph	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the t	underlying cause on	ven in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
	d by	-	· ·		, , ,		1 🗆 Ye	es 2 12 140 3 []	Probably 4 Unknow
l	Completed						24a. Was a	n 24h Wasa	outons of indiana availab
	m m			······			autops perforr	v prior t	autopsy findings available completion of cause of ?
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l	Be c	25. Was case referred to medical examiner?	Hospital:		Ott	har /	ath (Check only on		
	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Inpatient 2 28a. Date of Injury	28b. Time of				ence 6 Other (Sp ow injury occurred	ecify)
١	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		irk? ]Yes 2 □ No			
	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, st	reet, factory, office				Rural Route Number,
	erti	4 Homicide	building, etc. (Specify	1)			City or Town	n, State)	
	cal	(Check only 2 Medical Exam)	slcian: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	vestigation in my	oninion death occi	irred at the time d	ate and place, and d	up to the causeo(s)
	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	2	9d. Date signed (Mo	nth. Dav. Year)
		29b. Signature and title of certifier  Paramona  30. Name and address of person who control of the control of t			Ho	0.599	72	11/10	lack
		20 Namoundada	omploted source of death (fig.	232) /	Print)	0011		11/18	107
		So. Name and address of person who c	ompleted cause of death (Item	(Type	I In Ch	not C	6 1-	a ma	A . /
		Voucin In The	man and	11/0.00					

State of Maryland / Department of Health and Mental Hygiene For State Registrar 38698 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 11/16/2004 SYLVIA 4:00 A AREM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3300 LLEWELLYN FIELD ROAD OLNEY MONTGOMERY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Yrs. Director 04/09/1919 123-10-6039 NEW YORK Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location outenest internate the marked other than "natural," or Hems 23a or 28a-febow injury grother traumatic event, the Madical Exactinar must be notified at a. \*\*\* 10a State 10h County Yos 2 □ No MONTGOMERY OLNEY MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20832 U.S.A. 3300 LLEWELLYN FIELD ROAD death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 2 should be filed within 72 hours efter and Mental Hygiene. ie marked other than "natural, or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Year or Dates: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 HOSPITAL ADMINISTRATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LOUIS CAGAN ROSE GITLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other transmoore. 8300 EXODUS DRIVE, GAITHERSBURG, MARYLAND JOEL E. AREM/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡Burial 2 □ Cremation 3 □ Removal from State <sup>1</sup> 4 □Donation 5 □ Other (Specify) JUDEAN MEMORIAL GDNS 11/19/2004 OLNEY, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Approximate Interval Between Onset and Death tsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, alture. List only one cause on each line. Immediate Cause (Final disease of condition resulting in least) **Physician EMPHYSEMA** 15 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 1 ☐ Yes 2 ☐ No. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be HYPERTENSION, COR PULMONALE 1 XYes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2X No To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 1 Yes 2 □ No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 2 ☐ Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D26540 NOVEMBER 17, 2004 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16220 FREDERICK ROAD, GAITHERSBURG, MARYLAND SCHOENBERG, MD 31. Date filed (NOV 32. Degistrar's Signature 18 State 2004 racks Registrar

State of Maryland / Department of Health and Mental Hygiere 1 1 38699 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 45 BEATRICE ALMAN NOV 2004 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, DEC 2, 9. Birthplace (State or Foreign 1 ☐ M 2 🗓 F Days Hours NEW YORK Director 81 096-16-5933 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 UNITED STATES OF AMERICA Items 23a 6111 MONTROSE ROAD 20852 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE þ Specify: 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER PUBLISHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAX BERNSTEIN BELLA SEIDENSTADT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLIOTT ALMAN - SON 12527 CARRINGTON HILL ROAD, GAITHERSBURG, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If it
any injury gro cemetery, crematory or other place) 1 Note: The state of the state WASHINGTON CEMETERY 11/19/04 MONMOUTH JUNCTION, NJ 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
DANZANSKY COLDBERG MEMORIAL CHAPEL, 1NC
1170 ROCKVILLE PIKE, ROCKVILLE, MD, 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** athur sclarbe anosto vascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oneuronie Due to (or is a consequence of): Examiner the burial-transit Due to (or as a consequence of) Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Vital 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. 2 Accident investigation 1 Tyes 2 No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Word

32. Registrar's Signature

montron

**18** 2004

31. Date filed (Month, Day, Year)

NOV

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND#20a, b, coerFH, 12/2/04, EMW, MCO Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year ANN JUDITH BEN-AVRAHAM NOVEMBER 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Director 230-58-8053 1951 NEW YORK Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at Director 1X Yes 2 No MARYLAND MONTGOMERY GAITHERSBURG 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a 19522 BURLINGAME WAY 20886 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is markad other than "natural", or Itel Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 ROBERT GEORGE BERNSTEIN GERTRUDE MARCELLE SCHUTZMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important; If itam 27 is
any injury grother trai ROBERT G. BERNSTEIN/FATHER 19522 BURLINGAME WAY, GAITHERSBURG, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place)

National Crematory

National Crematory 20a. Method of Disposition Date 20c Location - City or Town, State Falls Church, Virginia + Surial 2 X remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/30/2004 Rockville, Mo 21. Signature of Funeral Service DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC +1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Jonald. 23a. Part1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician a NON SMALL CELL LUNG CARCINOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) P.O. ☐Yes 2☐No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, pe 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed? 2X No 2 🗆 No Division of Vital 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tyes 2**X**) No 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) U D35635 NOVEMBER 7, 2004 30. Name and address of pers in o completed cause of death (Item 23a) (Type, Print) 18111 PRINCE PHILIP DRIVE, OLNEY, MARYLAND 20832 JOSEPH KAPLAN, M.D., Day, Year)
18 32. Registrar's Signature State NOV Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year Physician Harold Benjamin Bitner November 25 2004 2:55AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Julia Manor Health Care Hagerstown Washington County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year July 11 12 5. Social Security Number 6. Sex M 2□ F 7. Age (In yrs. last birthday) 9 3 irthplace (State or Foreign **Funeral** Months Vrs Director 71 1933 Pennsylvania 220-28-3701 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be nedified at once. 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14104 Niswander Road 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 34 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 <u> Iaborer</u> Crane Mfg 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Jacob Bitner Rosa Mae Witmer 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) (Sister) 12812 Point Salem Road Hagerstown, Maryland 21740

Date | 20c. Location - City or Town, State Mary M. Carter 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 1 XBurial 2 Cremetion 3 Removal from State Cedar Hill Cemetery Nov.29, 04 Greencastle, PA 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of FecilityDouglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee, 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed igned by the attanding physician and be detached for use as the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. DId tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 XNO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: edical Certification: To 112 Yes 2□ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) erei Director: After this filled in by the funeral di 28b. Time of Injury 28c. Injury et Work? 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) hours aftar 4 | Homicide within 24 hours a

To the Funeral Completely filled 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 05 2327 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar Khalid M. Waseem

29

31. Dete filed (Month, Day,

19414-C Leitersburg Pike

32. Registrer's Signeture

Hagerstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 20 0 4 38702 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 15, 2004 ANITA BORDENICK 7:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) JUNE 1, 1919 **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 2 🕁 F Months Hours Min 577-22-2293 ROMANIA Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location or 28a-1 show 10d. Inside City Limits the Medical Examiner must be notified at 1 →Yes 2 No Director MARYLAND MONTGOMERY ROCKVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 MONTROSE ROAD 20852 UNITED STATES Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: natural', WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumstic event, tra Me Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN HOME HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOLOMON MICHNICK RACHEL 'UNKNOWN' 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELENE BORDENICK, DAUGHTER 10500 ROCKVILLE PIKE, #1616 ROCKVILLE, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) B'NAI ISRAEL CEMETERY 11/17/2004 OXON HILL, MARYLAND 21. Signature of Funeral Sonice Li ans 22 Name and Address of Facility NERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician arkinson's disease or condition resulting in death) disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by artery 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? dementa 24a Was an has 2 No 1 Yes 2 No 1 Tyes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide within 24 hours a

To the Funeral I

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

NOV 18 2004

C

mue C.

(Check only one)

29b. Signature and title of certifier

JASMINE

31. Date filed (Month, Day, Year)

32. Registrar's Signature

M.D.

Mu

GATTI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Montrose Road, Rockville, Maryland 20852

29c. License number

130034726

29d. Date signed (Month, Day, Year)

November 15, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental HygioRoft O. I.

			1 - For State Registra AMEND#19aperI	NF11/30/04,BM		Certificate of			eg. No.	38/03				
П	Physici	an	Decedent's Name (First, Middle, La	ŕ				2. Date of Dear Month	th Day Yea	3. Time of Death				
	/Medic	cal	Daniel Vincen  4a. Facility Name (If not institution, gi		ordelli		Landa (S. II.	Novembe	r 17, 200					
	Examir	ner		ŕ			Location of Death		4c. County of D					
	Euparal		4915 Baffin Bay 5. Social Security Number 6.		(In yrs. last birti	Rockvi.	II e If Under 24 Hrs.	8. Date of Birth	Montgo					
	Funeral Director		182-16-4529 Usual Residence of Decedent	1⊠M 2□F	87	Months Days	Hours Min.	(Month, Day,	Year)	Birthplace (State or Foreigr Country) nnsylvania				
	laryland show	2	10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
	the M	Director	Maryland Montgor	nery	ROCK	ville								
	th with 23a or	al Dir	4915 Baffin Bay	Lane		10f. Zip Code 2085	3	1	0g. Citizen of What USA	Country?				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event. The Medical Exalt har must be conflicted at ODGe.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1∑Yes 2 □ N If Yes, Give Year or Dates:1	0	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)						
Ş	2 hor	ted	15. Decedent's E	ducation	16a.	Decedent's Usual Occupa	ation		16b. Kind of Busine	ss/Industry				
21212-0030	within 7 ene. than *n	Completed	(Specify only highest gi	College (1-4or 5-	+)	(Give kind of work done of life. DO NOT use retired	during most of work ()	ing		,				
יי ס	filed Hygi ther	e C	17. Father's Name (First, Middle, Las			Teacher	18. Mother's Name	e (First Middle M	Educatio	on				
Maryland	uld be Mental rrked c	To B	Dominic Cordell	i				aticchi	maradii damamo,					
a <sub>Z</sub>	and Name	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Street a			City or Town, State	a, Zip Code)				
Σ	and 2 salth n 27 i		Crystal Corelli		49	915 Baffin E	Bay Lane,	Rockvil	le, MD 20	853				
Baltimore,	Pages 1 lent of He nt: If iten ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [ `4 ☐ Donation 5 ☐ Other (Speci		Meta	Disposition (Name of r, crematory or other place ropolitan		ber 18	20c. Location - City					
Balt	permit. Departm Imports any inju		21. Signature of Funeral Service Lice	good le	7)	ematory  22 Name and Addres Francis J. 500 Univer	s of Facility ins	Funeral	Homo Inc	. Virginia : .ng, MD 20901				
F			23a. Part1. Enter the disease, or con	aplications that caused	the death. Do no					Approximate				
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Chronic Renal Failure											
′	/Medical		resulting in death)		Renal I					Months				
	Examiner			_		, Disease				years				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	сопавдивлов о	n).								
	cuted	Examiner	that initiated events	c										
Ď,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence of	f):								
<b>68/6U</b> ,	ate b hysic the b	ledical		d										
	£ 20 G		IF FEMALE:	00- 1/										
O. Box	at the death cer by the altendi- tached for use	Physiclan/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of d Month	lelivery Day Year				
ī.	E Be		Part II. Other significant conditions	contributing to death bu	not resulting in	the underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?				
ras,	w requires that the been signed by th should be detache	ed by								Probably 4 Unknown				
Hecord	× Ω 70	plet						24a. Was an		autopsy findings available				
	The law cate has b page 2 st	Completed						autopsy perform	prior to	completion of cause of				
N II d	iclan: Th certificate rector, pag	O	25. Was case referred to medical				26. Place of Death			95 ZLINO				
_	di di	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Inpatien	t 2 ER/Outp	patient 3 DOA Othe		and the same of	nce 6 □Other (Sp	pecify)				
			27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day			at :	28d. Describe ho		,,				
0	Attending r death. ector: After by the fune	atle	2 Accident investigation	n			fes 2 □ No							
DIVISION	in Direction	Certification:	3 Suicide 6 Could not be determined		y - At home, farr (Specify)	n, street, factory, office		28f. Location (Str. City or Town,	eet and Number or I State)	Rural Route Number,				
	ie Hospital or 24 hours afte ie Funeral Diri	edical C	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of miner: On the basis of and manner state	examination and/	death occurred at the tim for investigation, in my op	e, date and place, a inion, death occurr	and due to the ca ed at the time, da	use(s) and manner at te and place, and du	as stated. ue to the cause(s)				
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mor	nth, Day, Year)				
	10		1 Jan	m.		D44	157		ovember 1					
			30. Name and address of person who Ira Berger, M.							2004				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		4								
	Registr		NOV 1 9 201		w 19	Sporks	/							

**Physician** 

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

6. Sex

4817 St. Barnabas Road

Amerto Canales

5. Social Security Number

**AKG** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

Temple Hills

Days

State of Maryland / Department of Health and Mental Hygier 0 0 1 - State Amend Item 23a, 27, 28a-f per me 6840 2-2-05 tags

Yrs.

7. Age (In yrs. last birthday)

0	0		0	1
్రే	H	7	U	4

Birthplace (State or Foreign Country)

10d. Inside City Limits

Onset and Death

1 ☐ Yes 2 No

El Salvador

3. Time of Death

3:30 A M

Reg. No.

Year)

2004

Prince George's

14. Race - American Indian, Black, White, etc. White

Lawn Care

4c. County of Death

2. Date of Death

Date of Birth (Month, Day,

November 8,

Month

**Funeral** Director with the Maryland s 23a or 28a-f show filed within 72 hours after Baltimore, Maryland 21215-0036 ō neturel the Medical then other other treumetic event, and Mental H should be

Box 68760.

P.O.

Division of Vital Records.

or Attending Physicien:

this

After

death.

after death

within 24 hours a To the Funerel 6

0

Be

Certification: To

Medical

1 M 2 □ F 223-91-2916 19 Nov. 27, 1984 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location Completed by Funeral Director Virginia Fairfax Lorton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9630 Mooregate Court 22079 El Salvador 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) El Salvadorian Specify. 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3 N/A Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jose Cruz Cannales 2 Maria Antonia Yanes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Heriberto Cannales (Brother) 9630 Mooregate Ct., Fairfax, Va. 22079 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages , <u>=</u> Anamoros La Union 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Importent: If eny injury or once. Anamoros La Union Cem. 11/25/04 El Salvador 21. Signature of Tuneral Sen 22. Name and Address of Facility Everly Community Funeral Care 7.0 36 6161 Leesburg Pk., Falls Church, Va. 22044 low 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Carbon Monoxide Intoxication Immediate Cause (Final Physician Caroline a robertly resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗙 No Completed page 2 should 24a. Was an certificate has autonsy

3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 28d. Describe how injury occurred unk 28f. Location (Street and Number of Rural Route Number, City or Town, State) 4817 St.Barnabas Rd Temple Hills, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

23d. Date of delivery

Day

Year

Month

29a. Certifier (Check only one) 29b. Signature and title of certifier

25. Was case referred to medical

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

examiner?

27. Manner of Death

2 Accident

3 Suicide

4 Homicide

Natural

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work?

1 ☐ Yes 2 XNo

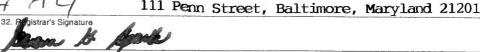
November 8, 2004

State Registrar 31. Date filed (Month, Day, Year)

ZABIUCC,

28a. Date of Injury Foundanth, Day Year)

11-8-2004



1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

Found in a car

28b. Time of

Found at 3:21 a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item# 10b,c,f,19b, perfff, INF, G839,1/25/05 II

For Unpend Item 23a&27 per me G838 12-8-04 tas
Registrar Certificate of Death
Reg. No. 2 Date of Death NOVEMBER 15, 2004 Stanley 5 4 1 Davis

3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:40 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE HOSPITAL CENTER CHEVERLY PRINCE GEORGES CO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. Mar. 11, 1 9. Birthplace (State or Foreign Country) 1962 South Carolina 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ★M 2 ☐ F 42 Yrs. 248-23-8362 Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show Itam 27 is marked other then "natural", or items 23a or 28e-f show other treumatic event, it is Next Examinar must be netitled all Columbia Richland XXYes 2 No Funeral Director Blythewood S.C. Fairfield the 10f. Zip Code **29203** 10e. Street and Number 10g. Citizen of What Country? **IISA** 316 Heritage Hill Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after and Mental Hygiene. 1 Yes 2 No If Yes, Give 1980— Year or Dates: 2003 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 反 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 4 yrs. Sr. Program Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Catherine Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Columbia 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a Beverly Thomas - Friend 316 Heritage Hill Dr. Blythewood, S.C. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Shiloh Presbyterian
Church Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If II any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) 11-20-04 Winnsboro, S.C. 22. Name and Address of Facility
Marshall's Funeral Home of Maryland
4308 Suitland Rd. Suitland, Md. 20 21. Signature of Funeral Service Licensee 20746 Approximate Interval Between Onset and Death 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cawse (Final disease or condition resulting in death) **Physician** Hypertensive atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of) Examiner dequer tistly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as the t attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an

cate has been sig , page 2 should b director, Be 2 Certification;

autopsy performed' 1**X** Yes 2□ No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? Yes 2 🗀 No

25. Was case referred to medical examiner? XXYes 2 □ No 27. Manner of Death

5 Pending investigation 6 Could not be

Hospital:

1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*WMadical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

1 Natural

3 Suicide

29a, Certifier

Accident

4 🖺 Homicide

29c. License number OCME 29d. Date signed (Month, Day, Year) NOVEMBER 17, 2004

30. Name and address person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 M.I) JACK

State Registrar 31. Date filed (Month, Day, Year)
DEC 0 7 2004

determined

32. Registrar's Signature

and manner stated.

Hospital or Attanding Physician:

after death.

24 hours a Funeral

within 24 ho
To tha Fune
completely f

filled in by

Medicai

		•	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H <i>rtificate of I</i>	lealth and M <i>Death</i>		2º 0 0 4	38706
4			Decedent's Name (First, Middle, Last	st)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Ruth Rae DeV	ries				November	12, 20°	04 5:00 A. M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of I	
			Montgomery Gene			01ney	I Williada a O.A. Ulas		Montgo	
	Funeral Director		0,0 0, 0511	ex 7. Age ☐M 2∏F 7. Age	(In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y)	1913 W	Birthplace (State or Foreign Country) ashington, DC
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-fs	ctol	Maryland Montgon	nery	Silver S	pring				1 ∏Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10g	. Citizen of Wha	
	s 23a	ra	15100 Interlacher			2090			U. S.	A.  American Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23e or 28e-f show event, it e Madical Exstitute must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	lispanic Origin? (Sp an, Mexican, Pu <i>e</i> rto Specify:	Rican, etc.)		White, etc.  White
8	thou		15. Decedent's Ed	1	16a. Dece	dent's Usual Occup	pation	16	b. Kind of Busin	
215	nin 72 In "na	plet	(Specify only highest gra	de completed)  College (1-4or 5-	(Give	kind of work done DO NOT use retired	during most of work d)	ing		•
21.	d with giene er the	Completed	Liomontary, Goodingary (G 12)	3 Years		memaker			Own Ho	ome
2		a l	17. Father's Name (First, Middle, Last)	•				e (First, Middle, Ma	iden Sumame)	
<u>X</u>	2 should be and Mental Is marked or raumatic eve	2	Milton Fein				Jenny Di			22226
Maryland 21215-0036	12 sh n and r ls m	o i	19a. Informant's Name/Relationship (			•		·		te, Zip Code) 20906
e,	1 and Healt em 2 thar		Sidney S. DeVries  20a. Method of Disposition	s - Husband						Spring, MD.
Baltimore,	Pages ment of l ant: If it		1 🛣 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, cre Mount Le	banon	11/14/	2004 Ad	elphi, N	Maryland
Bai	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked on y injury or other traumatic events.		21. Signature of Funeral Service Licer	Stattlem	uez ba	2. Name and Addre nzansky-0 70 Rockvi	ss of Facility Goldberg 1 ille Pike	Memorial , Rockvil	Chapels le, Mar	, Inc. yland 20852
	<b>3.</b> T. J. I		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each ligh	e death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arrest	-1	Approximate Interval Between
	Pnysician	0. 1	Immediate Cause (Final disease or condition	· Cours	1- super	tour-1	talu			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or 35 a	o resequence of):					
	Examine	L	Sequentially list conditions,	b. Due to /er es						
	ted sit	ulne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	axecu and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					=
68760	fficate be executed g physician and as the burial-transit	edical		_ d.						
_	CD 05									
Вох	leath certifi attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		☐Ectopic pregnancy	/		23d. Date o	,
	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death 5[	Other (specify)			Month	Day Year
P.O.	res that the de signed by the a be detached t		Part II. Other significant conditions of	contributing to death but	t not resulting in the I	inderlying cause giv	ren in Part I	23e Did tobar	co use contribu	te to the cause of death?
ds,	The law requires that the death cert tte has been signed by the attendini bage 2 should be detached for use a	d by	7 at the original and a second	on in ground	that rooming in the	moonying dadoo giv	OII II I WILL.			Probably Tunknown
COL	w requir been si should	Completed						24a. Was an		e autopsy findings available
Re	The lay	ошо						autopsy performe 1 ☐ Yes 2 🖸	prio	r to completion of cause of the
ta		Be C	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 ☑ h (Check only one)	NO IC	Yes 2□No
<u> </u>	ysician: nis certifica director, p	To B	examiner? 1 □ Yes 2 📉 No	Hospital: 1X Inpatier	nt 2 ER/Outpatie	nt 3 DOA Oth	ler: 4 ☐ Nursing Ho	me 5 Residence	e 6 Other (	Specify)
0	Attanding Physician: r death. actor: After this certificator, by the funeral director,		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day			y at rk?	28d. Describe how	injury occurred	
Sio	tandil eath. or: A the fu	catle	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b				Yes 2 □ No			
Division of Vital Records,	l or Attanc after death Diractor:	Certification;	4 Homicide determined		ry - At home, farm, st . (Specify)	reet, factory, office		28t. Location (Stree City or Town, S	et and Number o State)	r Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge, deat	th occurred at the tir	me, date and place.	and due to the caus	se(s) and manne	er as stated.
	to Ho	Medical	(Check only 2 Medical Exar	niner: On the basis of and manner stat	examination and/or in	ivestigation, in my o	pinion, death occur	ed at the time, date	and place, and	due to the cause(s)
	To the within 2. To the I complet	ğ	29b. Signature and title of certifier		_	29c. Licens	se number	29d	. Date signed (A	fonth, Day, Year)
	(0)		10 W	n		MD352	261	No	vember	12, 2004
	10		30. Name and address of person who John Yackee,	/						
	Sta	to.	31. Date filed (Month, Day, Year)		09 Prince			ey, Maryl	and 20	332
	Registi		NOV 18 20		m &	Sporks	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Ly Amend Item 1 per Dr., G838, 12 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Frances DeVergie 3. Time of Death Year **Physician** 12:04 PM 24 November 2004 /Medical 4c. County of Death N/A 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner Baltimere If Under 1 Year | If Under 24 Hrs. Maryland Medical Center University OF 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1,1938 Country) Pennsylvani 6 Sex **Funeral** 1□M 2ÅF Months Days Hours 183-30-3199 66 February Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits rel', or Items 23e or 28e-f show Examiner must be notified at Maryland Prince Georges Fort Washington 1 ☐ Yes 2 No Directo 100 Street and Number Washington Road 10f. Zip Code 10g. Citizen of What Country? 20744 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 Widowed 4 Divorced "neturel", marked other then "netur metic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Chief Clerk 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be n and Mental F William Colvin Carl Helen Marie Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 Is any injury or other treu once. Alain C. deVergie - Husband 12902 Ft. Washington Rd., Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11/28/2004 Edgewater, Maryland 4 □ Donation \_5 □ Other (Specify) 21. Signature of peral Service consee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Part 1 Enjerghe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Stage End Liver Disease /Medical Due to (or as a cons vuence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🖪 No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed certificate 1 ☐ Yes 2 No fo the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Sinpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2**X** No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Illan (Tundargh November 24 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

DEC 0 2 2004

Ilian Bandaranayake

31. Date filed (Month, Day, Year)

32. Registrar's Signature

22 S. Greene

ORIGINAL

Street

Baltimore MD 21201

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State of Maryland / Department of Health and	Mental Hygien 0 0 4

			1 - For State Registrar	State of Ma	aryland / De <i>C</i>	partme ertifica	nt of H te of L	ealth a Death	ind Me		en [2] ()	) 4	38708
			1. Decedent's Name (First, Middle, Last)							2. Date of Death Month		Year	3. Time of Death
	Physici /Media		Marie Kuhn Ed	ckel						Novembe		2004	4:20 ρ. <sup>M</sup>
7	Examir		4a. Facility Name (If not institution, give					Location of	f Death		4c. County	of Deeth	
			Mallard Bay Care				ambri		14 Hrs		I		ester
*	Funeral Director		5. Social Security Number 6. Security Number 1 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age ]M 2万€F	o (In yrs. last birthda 86 Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day,	Year)		lace (State or Foreign stry)
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	yland how		10a. State 10b. County		10c. City, Town or	Location						1	0d. Inside City Limits
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3	or 20	by Funeral Director	10e. Street and Number			10f. Z	p Code			10	g. Citizen of V	Vhat Cour	itry?
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28e-f show any injury or other traumatic event, the Medical Exercities must be richitled at ance.		1 Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Cambride				1/23	/04	Cambrid	ina M	ďΓ
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	Physician /Medical Examiner	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	ce	De	mei	in hie	÷1			Interval Between Onset and Death
.O. BOX 68/60,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	Physician/Medical E	IE FEMALE:	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	B□Ectopic p			- 57-3-		23d. Date Mor	e of delive	ry Day Year
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Division of Vital Records,	: The law requir cate has been si page 2 should I	Completed								24a. Was an autopsy perform	ed? P	rior to con eath?	osy findings available appletion of cause of
VII	Attending Physician: The redeath. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Otho			(Check only one	A CONTRACTOR OF THE PARTY OF TH		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiepe 0 0 L 38709 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 11/16/2004 1:35 P FRIEDMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ★M 2 ☐ F Yrs. Director 89 579-05-8029 01/19/1915 WASHINGTON, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show tems 23a or 28a-f shover remaining at 1 Ves 2 □ No MARYLAND MONTGOMERY ROCKVILLE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6105 MONTROSE ROAD 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE δ 3 ₩Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESMAN BAKERY itam 27 is markad otha other traumatic evant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FRIEDMAN CLARA KRAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) bertment of Health a creant: If itam 27 is injury or other trains. 3 HAZELWOOD CT, SMITHFIELD, NORTH CAROLINA 27577 TERI FRIEDMAN REID/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MOUNT LEBANON CEMTRY 11/18/2004 5 Other (Specify) \* 4 ☐ Denation ADELPHI, MARYLAND Departr Departr Importa any nji 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 11170 KOCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death Part 1. Enjer the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 23a. Part1. Immediate Cau (Final disease or condition resulting in death) **Physician** MULTIPLE ORGAN FAILURE /Medical Due to (or as a consequence of) Examiner METASTIC CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed MASSIVE ASCITIS burial-tran Due to (or as a consequence of) 68760, Physician/MedIcal HYPOVOLEMIA Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown SEPSIS 2ND TO FEVER Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an PERINTONITIS 2ND TO METASTATIC CANCER page 2 s autopsy performed? 1 ☐ Yes 2<del>X</del> No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ▼ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27, Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Funaral I 29a. Certifier ሺ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21891 NOVEMBER 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. WILLIE BLAIR, 7525 Greenway Center, Greenbelt, MD 20771 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 18 2004 NOV Registrar

State of Maryland / Department of Health and Mental Hygieneo o I

			For State Registrar	State	of Maryla		artment of F rtificate of		d Mental	Hygiene Reg. No	U U º	38710	
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	/Medic Examin		4e. Fecility Name (If not institution	4b. City, Town, o		Death	40	4c. County of Death					
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mit. Pages	S F S		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation, 5 ☐ Other (S		m State	cemetery, cre	matory or other pla		1/18/20			CH, VIRGINIA	
permit.			21. Signature of Funeral Service	Densee		EI	2. Name and Addre DWARD SAG 091 ROCKV	ess of Facility	ERAL DI	RECTION	, inc.	0852	
7			23a. Pert1 Enter the disease, or shock, or heart failue. List	complications the	at caused the de	ath. Do not en	ter the mode of dy	ng, such as car	rdiac or respira	tory arrest,		Approximate Interval Between Onset and Death	
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difficate		Medic	IF FEMALE:	1		311	_						
The law requires that the death certificate be executed	been signed by the attending party of the second be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetel death 3  Ectopic pregnancy 5  Other (specify) 9  Unknown								23d. Date of delivery Month Day Year		
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VIII	certifica rector,	Be	25. Was case referred to medica examiner?	Hospital:					Death (Check				
OIVISION OI VILA Fo the Hospital or Attending Physician:	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion: To	1   Yes 21 No 1   Inpatient 2   EP/Outpatient 3   DOA 4 N. Nursing							ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
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To the	To the	Me	29b. Signature and title of certifies	Tomsk	he Ma	y, mx	29c. Licen	se number	16	Nove	ite signed (Month	1, Day, Year)	
,	12		29b. Signature and title of certifies  29b. Signature and title of certifies  30. Name and address of person  Patricia Tom.  31. Date filed (Month, Day, Year,  NOV 18	who, completed co	ause of death (II	lem 23a) (Type Rock	Ville Pi	ke, Sui	te G-1	100, Ro	ckville,	MD 20852	
	Sta Registr	ate rar	NOV 18	2004	Hegistrar's Sig	nature 4	Sporks	/					

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importers: if Item 27 is marked other than "naturel", or Items 23s or 28a-f show any nijury or other treumatic event, the Medical Examinating the notitied at once.

Baltimore, Maryland 21215-0036

the attending physician and

Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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Examiner

within 24 hours a To the Funeral C

of or Attending Patter death. After 25. Was case referred to medical examiner?
1 Yes 2 □ No 27. Manner of Death \_ □ Natural 2.Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be

28a. Date of Injury (Month, Day Year) 1604

200 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1-105011N

1 ☐ Yes 2 XNo

Fa fell backwards while welk 28f. Location (Street and Number or Rural Route Number City or Town, State) 1500 Forest Glea.

17/04

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a, Certifier

29c. License number De061390 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IND

Charles Oh, MD 31. Date filed (Month, Day, Year)

NOV 19 2004

1500 32. Registrar's Signature

Forest Glen, Silver Spring

State of Maryland / Department of Health and Mental Hygien 004 38712 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edna Elizabeth Fluharty November 16,2004 1:20AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Eldercare-The Pines Talbot Easton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 17, 1 Easton 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Yrs. Director 1911 |Maryländ 93 217-03-5880 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or Items 23a or 28e-f ehow The Madical Examiner: wat be notified at 1 ☐ Yes 2 No Directo Maryland Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4305 Langrell Road 21655 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White <u>م</u> Specify: 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) Switchboard Operator Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Albert Arnett Emma Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree Robert A. Fluharty/Son 4305 Langrell Road, Preston, Maryland 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 11/17/2004 \* 4 ☐ Donation \_ 5 ☐ Other (Specify) Delmar, Delaware 21. Signatur, of Fureral Service Acen 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207, andre 106 Main Street, East New Market, MD 21631 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one earlier on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Due to (r s a consequence of): /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and is the burial-trans cardiac ician/Medicai as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□ Pregnant at time of death 5 Other (specify) ed by the detached Physi 9 Unknown Signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? rosclerosis, lung mass, hypertension 1 ☐ Yes 2 ☐ No 3. Probably 4 □Unknown Completed malhumtion, hypevolemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2.0 No 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by within 24 hours after To the Funeret Dire 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 3Summen M D57860 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NOV 1 9 2004

Seymour 31. Date filed (Month, Day, Year)

508 Idlewild Avenue egistrar's Signature Describe to Sparke

**ORIGINAL** 

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death

Maryland 21215-0036

Baltimore,

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After or Attending

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Vital

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			1- For State of Maryland / Department of For State Registrar Certificate of Registrar	Dooth	gie 2e 0 0 4 3 8 7 1 3 Reg. No.
	Physicia		1. Decedent's Name (First, Middle, Last). William Allan Hammond	2. Date of De Month	Day Year 3. Time of Death 29 2064 0629 1 M
	/Medic Examin			Location of Death	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 Months 1 Days 20-58-3223 7. Age (In yrs. last birthday) Months Days	Hours Min. (Month, Da	Washington th 9. Birthplace (State or Foreign Country) 1 1954 Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Manyl f sho	ō	TITE D. 1.1. Charles Term		1X Yes 2 □ No
	r 28a-	Director	W. Va. Berkeley Charles Town  10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
	h with	a D	623 Mordington Avenue 254	14	U.S.A.
92	be filed within 72 hours after death with the Maryland hal Hygiene od other than "natural", or Items 23a or 28a-f show avent, the Madical Exstrict mant be notified at	y Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of H If Yes, specify Cuba  1 □ Yes 2 □ No If Yes Give  1 □ Yes 2 ☑ No	ispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.) Specify:	
Ö	tural',	ed by	3 Wildowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occup	ation	White 16b, Kind of Business/Industry
7	in 72 "nal	Completed	(Specify only highest grade completed) (Give kind of work done	during most of working	Tob. Kind of Business/Industry
212	yiene.	шо	Elementary/Secondary (0-12)   College (1-4or 5+)   Horse train	er	Race track
פַ	~ ~ 0 ~	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	
<u>/lar</u>	should be and Mental marked o	To E	Freeman Jacob Hammond	Betty Mills	
Maryland 21215-0036	2 60 50 50	1		and Number or Rural Route Numb	er, City or Town, State, Zip Code)
	1 and 3 Health tem 27 other tra	- 3		roft Ct. 212-B	Hazerstown, Md. 21740
ltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place	Date	20c. Location - City or Town, State
	t. Pa rtmen rtant: njury	- 1	'4 Donation 5 Other (Specify) Cedar Lawn Mem. F		Hagerstown, Maryland
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Addre 415 E. Wil	PITHITC	h Funeral Home rstown, Md. 21740
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.	g, such as cardiac or respiratory a	Interval Between
E	Priysician		Immediate Cause (Final disease or condition a Colon Cancer		Onset and Death
k	/Medical Examiner		Due to (or as a consequence of):		
8			Sequentially list conditions, if any, leading to immediate  b. Atherosclerotic Card	ease	
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury		
	al-tra	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):		
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_	artifica ing ph e as th		IF FEMALE:		
P.O. Box	The taw requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of delivery  Month Day Year
	uires that the de signed by the a ld be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give		obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
Vital Records,	The law require ate has been si page 2 should b	Completed			osy prior to completion of cause of death?
ta		0	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only of	2 No 1 Yes 2 No
	Physician: this certificatal director, p	To B	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA		
o uo	ding After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Wor  M 1	y at 28d. Describe l k? Yes 2 □ No	how injury occurred
Division of	al or Attences after death	Certification:	3   Suicide 4   Homicide  6   Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or Tox	Street and Number or Rural Route Number, wn, State)
,	To the Hospital or Attending the Value of To the Funeral Direct completely filled in by the Value of the Valu	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	and the second s	
	To th withir To th comp	Me	29b. Signature and title of certifier (1) 1	e number	29d. Date signed (Month, Day, Year)
			( Willest to Do. FACEP H	40884	11 29 2004
		J.	30. Name and address of rson who completed cause of death (Item 33a) (Type, Print) The mas J. (5) West TH D.O. FACER WASHINGTON County	nty Hospital Had	1 E. Antietam St. Jerstown MD 21740
	Sta Registr		29b. Signature and title of certifier  30. Name and address of erspn who completed cause of death (Item 23a) (Type, Print)  The mas		,

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			For State Registrar	State of M	laryland		artment of I tificate of		nd Mental H	lygiene Rog. No		38714								
	Physici /Medic		1. Decedent's Name (First, Middle, La Margaret Pearl H						2. Date of Month	, Dav	y Year	A PAIL PATE								
	Examin		4a. Facility Name (If not institution, given Washington Count	re street and number			4b. City, Town, o		Death	1	County of Dea	ath								
	Funeral Director		220-16-0067	Gex 1 □ M 2 <b>X</b> 1 F	ge (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of (Month,	Birth Day, Year) 29,192		rthplace (State or Foreign Country) yland								
	show	20	Usual Residence of Decedent  10a. State 10b. County			Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No								
	or 28e-f	Funeral Director	Maryland Washing	ron	наде	erstow	10f. Zip Code			10g. Cit	izen of What C									
	s 23e	eral	417 Brewer Ave.	10 Mas Dandon	· Currie II C	10.1	21740		i=0./0	US		a de la Cara								
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28e-f show appring or other treumatic event, the Madical Evair matrical is stiffed at ance.		11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	? No		Mas Decedent of No fYes, specify Cub I□Yes 21X No		in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Whi									
9	2 hour	ted b	15. Decedent's E	ducation	: 	16a. Deced	lent's Usual Occup	pation		16b. K	ind of Business									
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Maryland 21215-0036	ould be Mental Marked o	To Be	Joseph Seibert Ch	nurchey				Mary	May Jamis	on										
Mar	and 2 sh saith and n 27 is m		19a. Informant's Name/Relationship Ethel Jones - Nie	* * * * * * * * * * * * * * * * * * * *			g Address <i>(Street</i> • High S		or Rural Route Nur Sharpsb	-										
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 [	Removal from State	1 000	ce of Dispo	sition (Name of natory or other pla	ce)	Date	-	ocation - City or									
ΕË	artment ortent: injury		' 4 ☐ Donation ) 5 ☐ Other (Speed	(v)	Mt.V		emetery	ss of Facility	1-29-2004	Shar	psbu <b>r</b> g,	Maryland								
Ba	permit. Departr Importe any inje		Vinto	1de		42	5 S.Cono	cochea	Osborne F gue St. W	unera illia	Msport,	,P.A. ,MD 21795								
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cause one cause on each	ed the death. line.	Do not ente	er the mode of dyi	ng, such as c	ardiac or respiratory	arrest,	- Utan	Approximate Interval Between Onset and Death								
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		UMO V	ua					4 weeks								
	Examiner		Sequentially list conditions	b. Chronic obstructive lung bisease  Due to (or as a consequence of):  Due to (or as a consequence of):								40.975								
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									,								
o,	ate be executed hysician and the burial-transit	Exar	that initiated events resulting in death) Last																	
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.O. Box 6	The law requires that the death certific tie has been signed by the attending page 2 should be detached for use as!	2	þ	ρ	by	þ	þ	hysiclan/Me	hysiclan/Me	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnanc	у			23d. Date of de Month	olivery Day Year
۵.	uires thet signed br Id be deta							Part II. Other significant conditions			-		ven in Part I.		а .	_	o the cause of death?			
ecol	law requir as been si 2 should l	Completed		Drahetese	mell	rtes	*		24a. W	as an topsy		utopsy findings available completion of cause of								
Division of Vital Records,	<b>sicien:</b> The lav certilicate has rector, page 2				ancer				pe 1 ☐ Yes	rformed?	death?	s 2 No								
Z.	/sicien s certit director	o Be	25. Was case referred to medical examiner? 1 □ Yes ◯ No	Hospital:	ient 2∏El	R/Outpatien	t 3 DOA Ott	205	of Death <i>(Check only</i> sing Home 5 Re		6 ∏Other (Spe	acifu)								
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isio	l or Attendi after death. Director: A in by the fu	licat	2 Accident investigation	2 Accident investigation 3 Suicide 6 Could not be						(Street an	d Number or R	tural Route Number,								
<u>&gt;</u>	tel or A s after el Direc ed in by	Certification:	4 Homicide determined	building, e	etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	, idealy, amor		City or 1	own, State	)									
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certiticate his completely filled in by the funeral director, page	dical									e to the cause(s)									
	To the I within 2: To the I complet	ğ	29b. Signature and title of pertifier  30. Name and address of person who  31. Date filed (Month, Day, Year)	any }_			29c. Licens	se number 449	96	29d. Dat	e signed (Mon	th. Day, Year) 27, 2024								
31	1-4		30. Name and address of person who	completed cause of	death (Item 2	23a) (Typa,	phans A	ed 1s	loonstoro	MO	. 2/7/	/3								
	Sta Registr		31. Date filed (Month, Day, Year) NOV 29 2	2004 32. Regist	trar's Signatu	re 4. Sp	ale													

State of Maryland / Department of Health and Mental Hygiens ( ) |

38715

							Cen	tificate o	f Death	)		Reg. No.	14 0	00110
			1. Decedent's Name (Fi	rst, Middle, Las	rt)					2.	Date of Dea	ath Dey	Year	3. Time of Death
	Physicia /Medic		Effie Mar	November 2							11:00 AM			
	Examin		4a Fecility Name (If not	institution, give	street end number,				4b. City, Te	own, or Locat	ion of Death	4c. County	of Death	
			Williamspor					# Hadaa 4 Va		amspor	-+	Washi	ngton	
П	Funeral		5. Social Security Numb	1	ex   7.Ag □M 25☑F	ge (In yrs. last	birthday) _ Yrs.	If Under 1 Ye Months Day			Date of Birt (Month, Day			ce (State or Foreign y)
	Director		431-38-0366 Usual Residence of Dec	5	~	89_	110.			N	ov. 2,	1915	Arkan	sas
	Puel Man	ı		o. County		10c. City, To	own or Loc	ation					10d	d. Inside City Limits
	Mery	ğ	Maryland Wa	ashingt	on	Willia	mspo	rt						1⊠Yes 2□No
	r 28e	Director	10e. Street and Number					10f. Zip Code	9			10g. Citizen of V	Vhat Country	y?
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	deat	Funerai	11. Marital Status		12. Was Decedent Armed Forces	Ever in U,S.	13. W	as Decedent of Yes, specify C	of Hispanic O	rigin? (Specif	y Yes or No-	14. Rac	e - American	
Q	or its		1 Never Married		1 Tes 2 If Yes, Give			□Yes 2□N			, 0.0.,			
90	72 hours efter death with the Merylend naturel, or thems 23e or 28e-f show areal Examiner must be notified at	ð Ð	3 ☐ Widowed 4 ☐		Year or Dates:			• • • • • • • • • • • • • • • • • • • •			· · · · · ·		"White	
Maryland 21215-0020	be filed within 72 hours ital Hygiene. d other than "naturei", event, the Maxical Exe	Completed by	15. (Specify o	Decedent's Ed nly highest gra	ucetion de com <i>pleted)</i>	16	Give k	ent's Usual Occ ind of work do O NOT use ret	cupation ne during mo:	st of working		16b. Kind of Bu	ısiness/Indus	stry
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an	ould be Mental arked o	Be	John Wesle		1				Inez			lie	,	
<u></u>	should bind Ments	ို	19a. Informant's Name/	-		1	9b. Mailing	Address (Stre				ar, City or Town,	State, Zip C	code)
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<u>a</u>	-155	Ŋ.	20a. Method of Dispositi		10007	20b. Place	of Dispos	ition (Name of atory or other p	•		Date	20c. Location -		
Baltimore,			1X Burial 2 □ Cr 4 □ Donation 5 □					l Cemet	•	12-	-1-04	Cabot,	Arkans	226
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ä	Depa impo any i	- (		46	MALL-							425 So		- 1 0170E
			23a. Parti Enter the di	ease, or comp	plications that cause one cause on each I	d the death. D	o not ente	nococne r the mode of c	eague S dying, such as	oT • W I	spiratory ar	SPORT, I	A	and 21795 Approximate
7	Physician		sho 🛋, or heart fail	lure. List only	one cause on each I	ine.							In O	nterval Between Onset and Death
and the	/Medical		Immediate Cause (Fina	I	<b>t</b> 0-	Fail	. ~ 4						~	nonths
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68760,	ete b hysic the b	Medical	that initiated events resulting in death) Last	<b>'</b> ]	C	Due to (or as	a consequ	ence of):						
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o.	the a	ysic	Part II. Other significant	t conditions co	entributing to death b	out not resulting	in the und	derlying cause	given in Part	I.			ntribute to th	he cause of death?
Ф.	The law requires that the deeth ste hes been signed by the atterpage 2 should be deteched for a	Completed by Physician	diabete	s m	ellitus	S					1 🗆 1	res 2 No	3 Probat	bly 4 ☐ Unknown
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ō	Physic this seal d	. To	27. Manner of Death		28a. Date of Inju	ıry 28t	. Time of	28c. In			-	ow injury occur		
o	Attending For death.  Detor: After by the funer	흹	1 Matural 5   2  Accident	□ Pending investigation	(Month, De	y rear)	Injury		Vork? ☐Yes 2☐	]No				
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Ö	s effe	Certification:	4 Homode	,	building, a	c. (Specify)					0.1y 0, . 0.1	, Cluidy		
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,	it-1		30. Name and address of	of person who	completed cause of	leath (Item 23a	Type, P	rint) Nurs	ing Hor	ne, 154	+ Nort	h Artiza	an st	reet
2		- 1	31 Date filed Month D	HARRY U	anas MD	are Signature			~ ~	illiam	sport,	Maryl	and a	21795
	Stat Registra	e ar	30. Name and address of Cynthia Ku 31. Date filed (Month, D	V 29 20	004 Die	J.	Spi	util						

DHMH 16 Rev 6/95

EFFIE Marie Hall

State of Maryland / Department of Health and Mental Hygiene 1 38716 1 - For Stete Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Elinor Louise Hose 2004 Nov. 10:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clearview Nursing Home Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Funeral 1 ☐ M 2 🗓 F 234-26-5001 82 Director May 31, 1922 West Virginia Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryla Department of Health and Mantal Hyglene.

Department of Health and Mental Hyglene.

Interpretant: If Item 27 is marked other then "naturel", or items 23e or 28e-f show any Injury or other traumatic event, the Madical Expenditure cust by notified at once. 1 ☐ Yes 2 X No Funeral Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12417 Cedar Ridge Road 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Grocery Store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Dempsey Sloss Ola May Gallatin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William L. Hose - Son 12417 Cedar Ridge Rd. Williamsport, MD 21795 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park | 11-29-2004 | Williamsport, Maryland 21. Signature of Fu teral Service 13 and 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failing. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Alghermen End Stee m /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ξ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Candis Vanc 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ 110 or Attending Physicien: ierel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 A Harsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number gett mo NOV 26 2004 D18019 31-3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 HAGERSTOWN, MD VASANT DATTA MD 340 MILLST 31. Date filed (Month, Pay, Year) NOV 2 9 2004 32. Registrar's Signature State Registrar all la justin our

State of Maryland / Department of Health and Mental Hygien 0 0 1 38717 1 - Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Ann Reid Hurley 0600 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Yrs. Director 215-26-5934 May 24, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avent. The Mudical Examples must be notified at 1 Yes 2 No Directo MD Dorchester Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Water St. 21869 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No white þ Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Wallace H. Reid Leona Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 I Allen T. Hurley husband P. O. Box 188, Vienna, MD 21869 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. \* 4 ☐ Donation \*5 ☐ Other (Specify) Salisbury Crematory 11/19/04 Salisbury, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee Lerros 700 Locust St., Cambridge, MD 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart FAILURE **Physician** 2 NKS. CONGESTIVE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the all 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIDE / ATTON 1 Yes 2 No 3 Probably 4 Unknown been VASCULIAS 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft investigation М 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M.O. 100 E. CARROLL M. SHIKAZI 31. Date filed (Month, Day, Year) 2 32. Pojistrar's Signature State 2004 Registra

State of Maryland / Department of Health and Mental Hygiene o o I

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	Examir		4a. Fecility Name (If not institution, g	ive street and number)		4b. City, Town, o	or Location of Dea	ith	4c. Count	y of Deeth		
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9	within 72 hours after deeth with the Marylan inen. inen. Ithan "natural", or Items 23a or 28a-1 show Itta Medical Examination must be notified at		1 ☐ Never Married 2 ☒ Married	1 XYes 2 No 1 If Yes, Give	963-	1 ☐ Yes 2 🔀 No		no nican, etc.)	Specia	ack, White, of	<sup>eιc.</sup> √hite	
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or o	w require been sig							1 🗆 Ye	s 2 □ No	3 Proba	ably 4 Ur	nknown
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	othe ithin othe omple	Med	29b. Signature and little of certifier	and manner stated.		29c. Licens	se number	29	d. Date signe	d (Month, I	Opy, Year)	
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			30. Name and address of person wh	o completed cause of death (II	tem 23a) (Type,	Print) /			/ /		/	
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<b>)</b>	Examin		4a. Facility Name (If no	ot institution, give	street and number)				r Location of Death		4c. County of De	
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	Funeral Director		5. Social Security Num 529.24		M 2□F	e (In yrs. last bii		Months Days		8. Date of Birth (Month, Day, Yo Sept. 29	,1922 U	lirthplace (State or Foreign Country) T
	pu N		Usual Residence of Do	ecedent 0b. County		10c. City, Tow	m or Local	tion				10d. Inside City Limits
	72 hours after death with the Maryland "naturel", or Items 23s or 28e-1 show offcal Examinational be notified at	20		Montgome	rv	Too. Oily, Ton		thersbur	<b>~</b> σ			1 ☐ Yes 2 No
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	ms 2	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S.	13. Wa	s Decedent of H	lispanic Origin? (Spec	rify Yes or No-	14. Race - An	nerican Indian,
9	after or Ite	Fui	1 Never Married	2X Married	Armed Forces? 1 XYes 2 ☐ N If Yes, Give		i	es, specify Cuba ]Yes 2፟X No	an, Mexican, Puerto F  Specify:	lican, etc.)	Black, Wi	
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Maryland	should hand Ment s marked umatic	_	19a. Informant's Name	e/Relationship (T	ype, Print)				and Number or Rural			
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ore	of He		20a. Method of Dispos		Removal from State	20b. Place o	of Dispositi	on (Name of cory or other place emorial	Novem	ber 20	c. Location - City of	or Town, State
Ë	Pag Iment Jury		°4 □Donation 5	Other (Specify	7	Par	k Cer	netery	20	04 R		, Maryland
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Importent: If item 27 Is marked eny injury opether traumatic e one.		21. Signature of Fund	ral Service Licent	twee	/			ss of Facility DeV Drive, Ga			
			23a. Part1. Enter the shock, or heart f	disease, or comp anure. List only o	lications that caused	the death. Do	not enter t	the mode of dyin	g, such as cardiac or	respiratory arrest		Approximate Interval Between
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م	that the dened by the a		Part II. Other significa	ant conditions co	ontributing to death b	ut not resulting i	in the unde	eriving cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
Vital Records,	uires signe ld be	d by	-		Failure	•		,				Probably 4 Unknown
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ta	dcien: Th	e C	25. Was case referred	to medical					26. Place of Death		No 1 □ Ye	os 2□ No
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Division	in the	Certification;	4 Homicide	determined	28e. Place of Injubul building, etc		am, street	, factory, office	21	City or Town, S		Rural Route Number,
_	lospital hours a unerel I		29a. Certifier 1	Certifying Phy	/sician: To the best	of my knowledge	e, death o	curred at the tin	ne, date and place, ar	nd due to the caus	e(s) and manner a	as stated.
	ne Ho n 24 h ne Fu sletely	edical	(Check only 2[ one)	Medical Exam	iner: On the basis of and manner sta	examination ar	nd/or inves	tigation, in my o	pinion, death occurre	d at the time, date	and place, and du	ue to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and till	e of certifier	1			29c. Licenso	e number	29d.	Date signed (Mor	oth, Day, Year)
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			30. Name and address						ad, Rockvi	11e, MD	20855	
	Sta	te	31. Date filed (Month,	Day, Year)	32. Registra	ar's Signature		Sparks				
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DHMH 17 Rev 1/2001

Registrar

		ľ	For State Registrar	State of Maryland		rtment of H			giene 004	38721
			Decedent's Name (First, Middle, Last	st)				2. Date of Dea	ath _	3. Time of Death
	Physici /Medio		JAMES E.	JONES				Month NOUEMBE	R 23 2	004 1:10 PM
	Examir		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of C	
			SUNBRIDGE	CARE / FLKTON	/	ELK10	N Hardon 24 Har	1 (8)	CEC	
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. las.	Yrs.	fi Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Date)	y, Year)	Birthplace (State or Foreign Country)  ASHLAND, N.C.
			Usual Residence of Decedent	20				DATIFIELD	T   1 - T	75/21/10 - 174.C.
	ryland		10a. State 10b. County		Town or Loc					10d. Inside City Limits
	Ba-f e	Director	PA. CITEST	ER	DXFU		<u>.</u>			1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number	I CA Dear		10f. Zip Code	17		10g. Citizen of Wha	4
	leath	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. W	as Decedent of Hi	spanic Origin? (Sp	pecify Yes or No-	9	American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow appinguy or other treumatic event, the Medical Examinat must be inclined at ance.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1 X Yes 2 No 1 Yes, Give Year or Dates: 1944 19	lf	Yes, specify Cuba  ☐ Yes 22500	n', Mexican', Puèrté Specify:	o Rican, etc.)	Specify:	White, etc.
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Maryland	ould be fi Mental F arked ot atic ever	Be c	17. Father's Name (First, Middle, Last)	15 (			18. Mother's Nam	A LO	ALLOEA!	
2	2 shouk and Me Is mark eumatik	2	19a. Informant's Name/Relationship	Type, Print)	19b. Mailing	Address (Street a	and Number or Ru	ral Route Numbe	or, City or Town, Sta	te, Zip Code)
M	and 2:		BONNIE H. JONI	ES /WIFE	27	5 UN	ON 50.	ROAD	OXFORD	A. 19363
ē,	es 1 a of He; of He; fitem r othe		20a. Method of Disposition	20b. Plac	e of Dispos	ition (Name of atory or other place		Date	20c. Location - City	or Town, State
Ē	Pages ment of ant: If it ury or o		1 Bunal 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		than me	SENACH BAL	TIST ALLISME	EL 27,204	NOTINELAN	1,PA-19362
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Feneral Service (Cer		22.	Name and Addres	s of Facility	DENN	AK	
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Θ	death certifii attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance	у				23d. Date of	delivery
Box .	Physician: The law requires that the death certificate has been signed by the attending this certificate has been signed by the attending ral director, page 2 should be detached for use as	by Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetel de 4 ☐ Pregnant at time of deat		Ectopic pregnancy Other (specify)			Month	Day Year
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of	Phy ar this aral d	); To	1 Yes 2 No  27. Manner of Death	28a. Date of Injury 28	Bb. Time of	3 DOA 28c. Injury	4 INUISING III		lence 6 Other (	Specify)
Division	nding Path. r: After e funer	Certification;	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		?? ∕es 2 □ No			
Vis	r Atte er de: recto by th	tifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tow		r Rural Route Number,
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	To the To the Comp	X	29b. Signature and title of certifier	1.		29c. License	number		29d. Date signed (M	
			Musul M.				6621		Nov. 24.	2004
			30. Name and address of person who							
	Sta	nto-	31. Date filed (Month. Day. Year)	370 WILMIN 32. Registrar's Signatur	6 TON	DE	19801			
	Regist		DEC 072	004 Deneva	6	Some	-			
						1	4			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 14, 2004 Fred Joiner 5:50 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** MONTGOMERY Casey House, Montgomery Hospice Rockville 8. Date of Birth (Month, Day, Y June 18, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Year) 1910 New York Days Hours 1₫M 2□F 577-32-6598 94 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland MONTGOMERY Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Ednor Road 20905 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☒️No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Producer of Films U.S. Government is marked other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Important: If item 27 is marked othe any injury, or other transmits. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carey Joiner Gertrude Eliza MacLeod 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Ednor Road Silver Spring, Maryland 20905 Mildred Joiner/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State injuryor 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/16/2004 Olney, New York Norbeck Mem. Park <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 an Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Aspiration Pneumonia Weeks /Medical Due to (or as a consequence of). Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (2000) 1000000 or injury Stroke Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2X No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 XNo Other: Certification: To 4☐ Nursing Home 5☐ Residence 6 € Other (Specify) Hospice 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide

Division of Vital Records, P.O. Box 68760. or Attanding Physician: filled in by within 24 hours a

Baltimore, Maryland 21215-0036

BR4216114 November 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Dr. #221 Rockville, Maryland 20850 Chitra Rajagopal, M.D. 31. Date filed (Month Day, Year) 32. Registrar's Signature NOV 18 2004

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

29a. Certifier

one)

(Check only

29b. Signature and title of certifier

Medical

State

Registrar

State of Maryland / Department of Health and Mental Hygien 2 0 0 L

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						Cer	tificate of l	Death		Reg.	No.	00,20
			1. Decedent's Name (First, Middl	e, Last)						of Death		3. Time of Death
	Physici		Elizabeth Hope	Kline					Mon		Day Year	3:50PM
	<ul> <li>/Media</li> <li>Examin</li> </ul>		4a Facility Name (ff not institution		r)		4	b. City, To	WOVEI wn, or Location of		25 2004 4c. County of Dec	
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-			Julia Manor He 5. Social Security Number		Age (In yrs. last	t hirthday)	If Under 1 Year					
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	Director		Usual Residence of Decedent						July	7 14 1	923 Mai	ryland
	Pug &		10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside City Limits
	aryla sh	2										1 ☐ Yes 2X No
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	it it	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What C	ountry?
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	eb = 1	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U,S.	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Ori	gin? (Specify Yes	or No-	14. Race - Am Black, Wh	
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8	within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 23s-f show ha Medical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	:			opecity.			Specify: W	11200
2	72 h	Completed	15. Deceden	t's Education st grade completed)	1	6a. Decede	ent's Usual Occupa	ation	t of working	16b.	Kind of Business	s/Industry
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Ö	lid be lentel ked o	To E	Ralph J. Stott	lemver				Fd	na Mason			
2	should b and Mente merked umatic e		19a. Informant's Name/Relations		Τ.	19b. Mailing	Address (Street				v or Town, State.	Zip Code)
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တ်	1 and Health em 27		20a. Method of Disposition	ic (nabana)		e of Dispos	ition (Name of atory or other plac	e '111	Date		Location - City or	
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		ń.	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. [	Do not ente	r the mode of dying	g, such as	cardiac or respira	tory arrest,		Approximate Interval Between
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r	H		30. Name and address of person	who completed cause o	death (Item 23	a) (Type, P	rint)	111	o Dack	Co	st it	nemotra
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/Medic		Champa Kingked								Novembe	_	, 2004		ам
Examin	er	4a. Facility Name (If not institution		number)				Location of				County of Dea		
Funeral		Holy Cross Hos  Social Security Number	spital 6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	Spri If Under	24 Hrs.	8. Date of Birt	th	ontgon 9. Bi	rtholace (State	or Foreign
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en: T tiffical tor, p	O	25. Was case referred to medica						26. Place	of Death	(Check only o	2 ( <b>)</b> (No	1016	5 2 110	
Physicien: Th this certificate al director, pag	To B	examiner? 1 □ Yes 2 <b>204</b> 0	Hospital:	patient 2	ER/Outpatie	nt 3 DC	Othe	er: 4□NL	ırsing Hom	ne 5□Resi	dence 6	Other (Sp	ecify)	
ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pendir		ate of Injury Month, Day Year)	28b. Time of Injury		8c. Injury Work	c?		8d. Describe	how injury	occurred		
tendi leath. tor: A	catl	2 Accident investig	not be			M		Yes 2		Of Location /	Ctrant no	d Mirmhon on f	Sum I Florida Ali	b
l or At after of Direct	Certification:	4 Homicide determ	ined   288. PI	ace of Injury - At huilding, etc. (Speci	ify)	reet, tactory	, oπice		2	City or To	wn, State)	I Number or F	Rural Route Nu	imber,
To the Hospitel or Attending Physicien: The law within 24 burus after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifyir (Check only one) 2 Medicel	Examiner: On th	the best of my known and the basis of examination and the basis of examinations and the basis of examinations are stated.	owledge, deat ation and/or in	h occurred westigation	at the tim , in my of	ne, date an pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) date and	and manner a place, and du	is stated. le to the cause	(s)
o the	Mec	29b. Signature and title of certifie	r		1 1 20	290		e number			29d. Date	signed (Mor	nth, Day, Year)	
F 3 F 8		Rena	ma c	iang	MD		D6	08:	26		11	116/0	4	
V		30. Name and address of person			m 23a) (Type,						/_		<del>/</del>	
		Kshama	Gar	9 MD	1780		4011	ingsi	wort	h Dr.	SIL	ver Sp	ring M	D
Sta Registi		31. Date filed (Month, Day, Year)		2. Registrar's Sign	ature 6	So	ack					1	J	

2. Date of Death

	Dallillore, Maryland 21213-0030
Ph	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
y:	Department of Health and Mental Hygiene.
5il	Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show
li	The state of the s

	Physici /Medic		ROBERT				KING		Novemb	er 16, 2	2Ŏშ4	12:40A
	Examin		4a. Fecility Name (If not institution, giv Renaissance Cardens a	e street and numbe t Riderwood	" Villag	æ	4b. City, Town, or Location of Death Silver Spring			4c. County of Death Prince George's		
F	Funeral Director		5. Social Security Number 5.10–10–6976 6. S	ex 7. A ▼M 2□ F		ast birthday) 36 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da OCt. 30	7, 1918	9. Birthp Cour Kans	lace (State or Foreig htry) Sas
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c Cib	, Town or Lo	antion					Od. Inside City Limits
	e Maryla Ba-f shov	ctor	Maryland Montgome	ery			Spring					1 ☐ Yes 2 XNo
	th with th	al Director	10e. Street and Number 3148 Gracefield I	Road, #20	5		10f. Zip Code	0904		10g. Citizen of United		,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f show amounts: If item 27 is marked other than "natural; or itams 23a or 28a-f show any injury or other traumatic avant, Ite Madical Erapinar must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 2 I If Yes, Give Vear or Dates	s? ]No WWTT	1	Nas Decedent of H f Yes, specify Cuba I ☐ Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White.	
21215-0036	thin 72 hc e. an "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	r 5+) <sub>A</sub>	(Give life. L	DO NOT use retire	during most of world	king	16b. Kind of B		dustry vernment
nd 21	oe filed wi al Hygien d other th	Be Con	17. Father's Name (First, Middle, Last		4	Apprai	iser	18. Mother's Nam		, Maiden Sumar		/ermenc
<u>ya</u>	ould b Ment Markac	٦ ا	Ira L. King			11 22 10 1		Dora	Field			
, Maryland	and 2 sheath and 2 27 is m		19a. Informant's Name/Relationship ( Darlene L. King	• • • • • • • • • • • • • • • • • • • •				eld Rd.,				Md. 20904
Baltimore,	Pages 1 ent of He nt: If Iten		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif		G	ametery, cren	sition (Name of natory or other place tan Crem	ca)	Date /18/2004	20c. Location Alexan		wn, State Virginia
Balti	permit. Departm Importal any inju		21. Signature of Funeral Service Licer	Beraw	wat			Borgwardt				land 2070
68760,	batto certificate be executed by Medical Examination and a strending physician and doruse as the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	tau as a consequence as a consequence as a consequence as a consequence	iple uende of): Sidu	veno	c to t es the efficile	odno		ism	
.O. Box 68	9 e	ysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pregnancy Other (specify)	/			te of delive	ory Day Year
Δ.	uires that the signed by th Id be detache	d by Phy	Part II. Dther significant conditions	contributing to death	but not resu	ulting in the ur	nderlying cause giv	ren in Part I.	23e. Did t			ne cause of death?
l Records,	The law requires that the rate has been signed by the page 2 should be detach	Completed	works						24a. Was autor perfo	osy ormed/	Were autoprior to cordeath?	psy findings available appletion of cause of 2 No
Vital R	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	11				26. Place of Dea	th (Check only o	one)		
of	S S S	To	1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatien		4 Nursing H		dence 6 Oth		<i>'</i> )
Division	lending Ph eath. or: After th the funeral	cation	27. Manner of Death  1		Day Year)	Injury	Wor	k? Yes 2 □ No				
Divi	tal or Attences after death al Diractor: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	200. Place of I	Injury · At ho etc. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	I Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funaral Diractor: After completely filled in by the fune.	edical		nysicien: To the beariner: On the basis and manner	of examinat							
		M	29b. Signature and title of certifier	huma	na, h	ND	29c. Licens	59524		29d. Date signe		
	İc		30. Name and address of person who LOVEEN T PUTH (	completed cause of	f death (Item	23a) (Type	Print) EFIELD	ROAD, S	ILVER	SPRIN	G M	D 20904

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (*Month, Day, Year*) **NOV 18** 2004

		•	For 1 = State Registrar	State of Maryla		artment of H <i>tificate of l</i>			gie <b>że ()</b> () Reg. No.	4 38/26
			Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physicia		Lester La	nsing King	g. Jr.			Novembe	•	. M
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c. County	of Death
			6504 Pilgrims Cove			Derwoo			Montg	omery
	Funeral Director		5. Social Security Number 6. Sex 1反 Number 1反 Number 1反 Number 1反 Number 1反 Number Nu	7. Age (In )	vrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Jul 27,	th 19, Year) 1936	9. Birthplace (State or Foreign Country) Maryland
,			Usual Residence of Decedent							
	how		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
-	e Ma	cto	Maryland Montgome	ery	Derwo					1 ☐ Yes 2 No
-	or 26	Director	10e. Street and Number			10f. Zip Code	0==		10g. Citizen of W	
-	23a	rai	6504 Pilgrims Cove				855	N N -	United	
	or Items	Funerai	11. Marital Status  1 □ Never Married 2 ▼ Married	1 X 105 2 100	. ) ) /	Was Decedent of H 1 Yes, specify Cuba 1 ☐ Yes 2 🗓 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)		e - American Indian, k, White, etc. : White
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment: If them 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	3 Widowed 4 Divorced  15. Decedent's Educa	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Bu	
2	n 'n	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work d)	ang		
3	r tha	E	Elementary/Secondary (0-12)	2	Inst	ırance Di	rector		Trade A	ssociation
2	othe vent,	Bec	17. Father's Name (First, Middle, Last)						, Maiden Sumam	θ)
3	Menta Menta arked attc e	ToE	Lester Lansing K						y Gibson	
2	2 sho		19a. Informant's Name/Relationship (Type			ng Address (Street				
<u> </u>	and lealth m 27 her ti			ouse)		Pilgrims				City or Town, State
5	O SET OF		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State		sition (Name of matory or other place	1	-		
	rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funera (Sprvice License)	Pa	~	Memorial  Name and Addre				le, Maryland
0	Depermine any ir		Muchan	Denle	Son!	lû E. Dee	r Park Di	rive - (		me burg, MD. 20877
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do not en	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Ŧ	hysician		Immediate Cause (Final disease or condition			al Cancer				3 ½ Years
	/Medical Examiner		resulting in death)	Due to (or as a cor						
H	LAdiimici	_	Sequentially list conditions, b.	Due to for as a cor	spaniero di					
	e sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 to (01 as a co	isoquenee on.					
	and and II-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cor	rsequence of):					
00/0	icate be executed physician and s the burial-transit	ie H								
	ficate p physics the	edicai	u.							
Š	n cert	Z/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pr		⊒Ectopic pregnancy	u.			e of delivery
	es that the death certifigned by the attending be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		Other (specify)	,		Moi	nth Day Year
5	at the by th	hys	9 🗆 Unknown					on- Did		should be the equipped death?
ה ה	The law requires that the death centifies the has been signed by the attending bage 2 should be detached for use as	by	Part II. Other significant conditions cont	ributing to death but no	t resulting in the u	inderlying cause giv	ren in Part I.	_		ribute to the cause of death?  3 ☐ Probably 4 ☐Unknown
cords,	w requir been s	etec						24a. Was	24h V	Were autopsy findings available
ב ב	ne law has l ge 2 s	ompieted						auto perfe	ppsy pormed? c	prior to completion of cause of death?
	n: Th ficate r, pag	O	OS Mary and the modical				26. Place of Dea	1 Yes		Yes 2 No
VII	Physicien: rthis certifica ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpatie	nt 3 DOA Ott	100		idence 6 Oth	er (Specify)
5	ding Physicien: The lav h. After this certificate has funeral director, page 2	<b>H</b>	27. Manner of Death	28a. Date of Injury (Month, Day Yea			ry at		how injury occurr	
5	Attending ir death. ector: After by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOHIII, Day 198	ar) Injury		Yes 2 □ No			
<u>2</u>	Atter	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S)	At home, larm, st	reet, factory, office			(Street and Numb	er or Rural Route Number,
5	tal or s afte el Dir ed in	Cert								
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Alt completely filled in by the fun	edical	29a. Certifier 1X Certifying Physic (Check only one) 2 Medical Examin	er: On the best of my er: On the basis of exa and manner stated.	y knowledge, dea mination and/or in	th occurred at the til evestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma , date and place, a	nner as stated. and due to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signer	d (Month, Day, Year)
	- 1	İ	1 Hours	· C 50	top	— D43	083	1	November	18, 2004
-	20-11		30. Name and address of person who cor			, Print)				
			George Sotos - 9				00 - Rocl	kville,	Marylan	d 20850
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		book				
	Registr	2012	1963 V J (7 / 111 )	4	~	ALCO WILLIAM	La Company			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 2004 38727 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 14, 2004 **Physician** Vivian J. Little 9:50 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince Georges Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 💢 F 227-22-8022 88 **Director** July 22, 1916 Virginia Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or wher traumatic event, the Moural Examiner must be multified at once. 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6107 Welshire Court 20772 United States Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black δ. 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 License Practical Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Early Johnson Mary Lee Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin A. Little, Sr. 6107 Welshire Court, Upper Marlboro, MD 20772 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baptist Cemetery 11/20/04 Lynchburg, VA 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee ludré 7400 Georgia Ave. N.W., Wash. D.C. 20012 Hamplon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 4X Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Dan 2 No 1 ☐ Yes 2 ☐ No 1□ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital c within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) allevolis D0024208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 39 26 Wood AR4LHASAN ANSAQ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 18 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 4 1 - For State Registrar 38728 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 15, 2004 **Physician** 9:55A ARTHUR LINDNER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Day, Year), FEB. 15, 1949 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 1₩ 2□ F NEW YORK 55 110-40-0388 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. Counts 10d. Inside City Limits in then "naturel", or Items 23s or 28s-f show 14 Yes 2 □ No Directo MARYLAND ANNE ARUNDEL CROFTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2518 WINDY OAK COURT 21114 UNITED STATES OF AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or lier eny lature or other traumatic event, its M. alc. Exercit at once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ METEOROLOGIST METEOROLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE LINDNER LILLIAN SPIWACK ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2518 WINDY OAK COURT, CROFTON, MD 21114 ELEANOR LINDNER - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☒ Removal from State NEW MONTEFIORE CEM. 11/17/04 PINELAWN, NEW YORK 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 11170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Metastatic Colon Cancer years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) the attending physician Records, P.O. Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 3☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 K Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) feral Beili, D 46052 11-15-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sideral Bech, MD 2001 Mechcal Poul way Sideral Bech, MD annapolis, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 18 2004 Registrar

			For State Registrar		State of Ma	aryland / Do (	epartment of Ce <i>rtificate o</i>	Health and f Death		gienje () Reg. No.	104	38729
	Physici	an	Decedent's Name						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al		ward Laws			1 to 05 T		Novembe			10:50 P <sup>M</sup>
	Examin	er	4a. Fecility Name (If					or Location of Dea	tn		unty of Death	
E-	uneral		5. Social Security Nu	ss Hospit		e (In yrs. last birth	day) If Under 1 Ye				tgomer 9. Birth	y place (State or Foreign intry)
	irector		097-24-45	21	DM 2□F	72 Yr	s. Months Day	's Hours Min	09/17/	ly, Year) L932		ington, DC
P	<b>&gt;</b> -22		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	or Location					10d. Inside City Limits
faryla	shove	ō		,								1 ☐ Yes 2 ☑ No
the N	28a-f	Director	MD 10e. Street and Num	Prince G	eorge s	Adelph:	L 10f. Zip Code			10g Citizen	of What Cou	
death with the Maryland	3a or			zerott Ro	2d #A6		20783			U.S.		,
death	E E	Funeral	11. Marital Status	ZCIOCC RO	12. Was Decedent Armed Forces?		13. Was Decedent of If Yes, specify C		Specify Yes or No		Race - Ameri	can Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours after th and Mental Hygiene.	rthan "natural", or items 23a or 28a-f show the Medical Examinational be ricitified at	by	1 ☐ Never Marrie 3 ☐ Widowed	ed 2⊠ Married 4 □ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:		1 ☐ Yes 2 X N		to rican, etc.)		Black, White,	ack
<b>5-0</b>	natur	Completed	(Speci	15. Decedent's Editify only highest grad	ucation de completed)	16a. D	ecedent's Usual Occ Give kind of work do	supation ne during most of wo	orking	16b. Kind	of Business/Ir	ndustry
. <b>1215</b> within 72 ene.	han a	mpl	Elementary/Secon		College (1-4or 5	)+)	Give kind of work do ife. DO NOT use ret	ired)	•	P - 1 -	1 0	
filed v	다 다		17. Father's Name (	(First Middle Last)	3	Suj	pervisor	18 Mother's Na	me (First, Middle			vernment
aryland should be f nd Mental I	5 5	To Be		ward Laws	on Sr				Henry	,		
aryla should l	27 is marked r traumatic	ř	19a. Informant's Na			19b. M	Mailing Address (Stre			er, City or To	wn, State, Zij	p Code)
	em 27 is other tra		Jill Rho	des Lawso	n, Spouse	180	)2 Metzero	ott Rd. #A	6, Adelp	ohi, M	arylan	d 20783
98 1 g	I tem 2 r other		20a. Method of Disp		Domeyal from State	20b. Place of D cemetery,	isposition (Name of crematory or other p	nlace)	Date	20c. Locati	ion - City or T	own, State
Pages Ment of	d'un il		° 4 ☐ Donation	5 Other (Specify			coln Crem		17/2004	Brent	wood,	Maryland
Baltimore, permit. Pages 1 ar	Important: If Itel any injury or oth		21 signatu of Fu	era Service Dicens	au ()	+	22. Name and Add	tress of Facility CVille Pik	Simple T			and 20852
			23a. Part1. Enter #	ne disease, or comp	plications that caused one cause on each li	the death. Do no						Approximate Interval Between
Phy	sician		Immediate Cause ( disease or condition	Final	Pancre							Onset and Death  1 week
	edical miner		resulting in death)		a	a consequence of	:					
LAG			Sequentially list cor	nditions,	b. — Due to lor as	a consequence of	NE CONTRACTOR					
peq	sit	nine	cause. Enter Under Cause (Disease or i	injury	One to for as	a consequence of						
жесп	sician and burial-transit	Examiner	that initiated events resulting in death) L		c. Due to (or as	a consequence of	:				-	
<b>68 / 60,</b> ificate be executed	ysiciar e buri	edical			d							
	ng physi as the b	Medi	IC CCMALC.									
. Box	attending I for use as	Physiclan/M	IF FEMALE: 23b. Was decedent in the past 12	pregnant		2 Fetal death	3 □Ectopic pregna			23d.	Date of deliv	ery Day Year
) H	by the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant at 9□ Unknown	time of death	5 Other (specify)					54,
J. ja	de ed		Part II. Other signifi	icant conditions co	ontributing to death b	ut not resulting in t	he underlying cause	given in Part I.	23e. Did t	obacco use	contribute to t	the cause of death?
VITAI RECORDS, P.O lician: The law requires that the	E e	d by							1 🗆 '	Yes 2 <b>X</b> N	lo 3 Proi	bably 4 □Unknown
CO M	s been sign	ompleted							24a. Was		4b. Were auto	opsy findings available
<b>교</b>	page 2	ошо								osy ormed? 2X No	prior to co death? 1 \( \text{Yes}	empletion of cause of
	certificate rector, pag	Be C	25. Was case referr	red to medical				26. Place of De	ath (Check only o		, 3, 103	20110
of Vita Physician:	S D	To	examiner? 1 ☐ Yes 2 💢	No	Hospital: 1 X Inpatie		atient 3 DOA	Other: 4 🗆 Nursing I	Home 5 Resi	dence 6 🗆	Other (Specia	fy)
	After th funeral	on:	27. Manner of Death 1 X Natural	5 Pending	28a. Date of Inju (Month, Da	ry 28b. Tir y Year) lnji	ury V	Vork?	28d. Describe	how injury oc	ccurred	
VISION Attending r death.		Icati	2 Accident 3 Suicide	investigation  6  Could not be		uny - At home fam	M 1	☐ Yes 2 ☐ No	28f Location (	Street and N	umher or Rus	al Route Number,
= 2 =	Director: I in by the	Certification:	4 Homicide	determined	building, et	c. (Specify)	i, stieet, ractory, oriit	,0	City or To		uniber 0, 71011	ar riodie rvaniber,
Hospital	e Funeral D letely filled i	edical C	29a. Certifier (Check only one)	1 N Certifying Phy 2 Medicel Exem	/sicien: To the best iner: On the basis of	f examination and/	death occurred at the or investigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) and date and pla	d manner as s ice, and due t	stated. o the cause(s)
o the	To the Function	Med	29b. Signature and	title of certifien	and manner sta	es sorial.	29c. Lice	ense number		29d. Date si	gned (Month,	Day, Year)
⊢ ≯	F 0		> PLA	O. KOX			D006	1768		11/16	/2004	
			30. Name and addre	ess of person who d	completed cause of d	leath (Item 23a) (T				,,	, 2007	
					0 Forest				yland 20	910		
, A	Sta Registr		31. Date filed (Mont	th, Day, Year) V 18 200	32. Registr	ar's Signature	Spark					

State of Maryland / Department of Health and Mental Hygiphe [] [ Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Ngoc November 16, 2004 3:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 11211 Lombardy Road Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Yrs. 79 Vietnam Director 556-89-9840 March 1, 1925 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic svent, if a Medical Exer in at must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a 11211 Lombardy Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. In Important: If item 27 is marked other then "naturel", or item any injury or other treumatic svent, If a Meulical Ever it and once. 1 ☐ Yes 2 🖾 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cuu Tho Lam Tram Thi Le 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anh Thi Lam/ Daughter 21222 Dorsey Spring Place, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Date 20c. Location - City or Town, State 20a. Method of Disposition ₩Burial 2 Cremation 3 Removal from State November 20 4 ☐ Donationy 5 ☐ Other (Specify) Silver Spring, Maryland 2004 Cemetery 21. Signature 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. over 500 University Blvd, W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Chronic Pancreatitis 10 Years resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertrophy of Prostate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 10 years Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Vascular Insufficiency 5 Years that initiated events resulting in death) Last end Due to (or as a consequence of): P.O. Box 68760, the attending physician Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9□ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatore and title of certifier 026894 November 18, 2004 ne 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dana C. Bui, M.D. 831 University Blvd, East, Silver Spring, MD 20901 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State **NUV 18** 2004 Registrar

State of Maryland / Department of Health and Mental Hygion ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 16, 2004 Ester LESHCHINER 11:10 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 12, 1923 9. Birthplace (State or Foreign **Funeral** 1□M 2√2 F Months Days Hours Ukraine Yrs. 212-02-9163 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filad within 72 hours after deeth with the Meryland Departmant of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23e or 28e-f show eny injury or other traumetic event, the Medical Examiner invatibe notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 √Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7620 Maple Avenue #501 20912 United States Funerai 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0020 Specify: white 1 ☐ Yes 2 ☐ No Specify. δ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Urman Manya Skvirchack 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Nathan Leshner, Son 8918 Falls Farm Drive, Rockville, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 11/18/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St. NW. Washington DC.

23a. Part Exertis Issase, or complication that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, if heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Bilateral Pneumonia Examiner Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Pancreatic Cancer With Metastasis to Liver bunel-transit or Attending Physicien: The law requires that tha death certificate ba executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Congestive Heart Failure Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) se esn Deep Vein Thrombosis Part II. Other aignificant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Atrial Fibrillation within 24 hours after deeth.

To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 1 ☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4\( \bar{\text{Nursing Home}} \) Nursing Home 5 \( \bar{\text{Nesidence}} \) Residence 6 \( \bar{\text{Other}} \) Other (Specify) Hospital: 1∐ Yes 2∐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 2 10 D 20274 November 16, 2004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kirti Vohra, M.D., 7710 Bradley Boulevard, Bethesda, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 19 2004 Registrar

s	•		For Amend Items2&3		d / Depa	artment of H	ealth ar			38732
	n, Dhuaisi		Registrar WCHD/SH 12/  1. Decedent's Name (First, Middle, Last)	2/04 per Dr.		uncate of L	Jean	2. Date of De. Month	Reg. No.	04 3. Time of Death
	Physicia /Medic		Gary Benjamin Litt					Nov	26 2001	11340 7
	Examin	er	4a. Fecility Name (If not institution, give s 12832 Cathedral Av			4b. City, Town, or Hagersto		Death	4c. County of Dea	on County
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24			thplace (State or Foreign ountry)
ľ.	Director		216-32-3168	M 2□F	71 Yrs.	Months Days	Hours	Min. (Month, Da Aug 15	5 1933 Mar	yland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	a-fsh	ctor	Maryland Washingt	ton	Hagers	town				1 □ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	eath v	eral	12832 Cathedral Av	VC •	S 12 1		742	2 (Specify Vac or No	U.S.A.	orican Indian
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic event. The Medical Exam had must be notified at	by Funeral	1 Never Married 2 XMarried 3 Widowed 4 Divorced	Armed Forces?  1		f Yes, specify Cubar	Specify:	n? (Specify Yes or No Puerto Rican, etc.)		
21215-0036	72 ho 'natur	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired)	ation furing most of	f working	16b. Kind of Business	/Industry
121	within ene. than "	dmo	Elementary/Secondary (0·12)	College (1-4or 5+)			)		Thereals Mf	·~
	illed Hygi other	Be Co	12 17. Father's Name (First, Middle, Last)		Mac	hinist	18. Mother's	Name (First, Middle,	Truck Mf Maiden Sumame)	9
ylan	should be and Mental marked c	To B	Benjamin P. Little	9			Gra	ce Peral (	Coffman	
Maryland	12 sho		19a. Informant's Name/Relationship (Typ						er, City or Town, State,	
	1 and Health tem 27		Irene Anna Little 20a. Method of Disposition	(Wife)	lace of Dispo	sition (Name of	!	e. Hagerst	cown Maryla 20c. Location - City or	
<u>o</u> E	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State Sm:	emetery, cren ithsbu	natory or other place rg Cremato	ory¦11	/27/04	Smithsburg	Maryland
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature I Fureral Service License	Paul	22	. Name and Address	s of Facility	Douglas A.	. Fiery Fun	eral Home
<u> </u>	20529		Manus 1	alley Ir.	1	331 Easte	rn Bly	d. N. Hage	erstown, Ma	ryland 21742
I	Discostation		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the death e cause on each line.	n. Do not ent			rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	. Due to (or as a consequ	uence of):	lane	e -			21 months
L	Examiner	_	Sequentially list conditions, b							
	ted	Examiner	Sequentially list conditions, fary, leading to innuiciate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequ	uanea ot):					
oʻ	ate be executed hysician and the burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					
8760,		lical	d							
9	eath certific attending p	Physiclan/Medical	IF FEMALE:	3c. If yes, outcome of pregna	incv				004 Bass at 45	
Вох	death death death death	iclan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
P.O.	res that the de signed by the a i be detached f	hys	9 Unknown	9□ Unknown						
	signed d be de	by	Part II. Other significant conditions con	tributing to death but not resi	ulting in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use contribute to √es 2 □ No 3 □ P	the cause of death?
Cor	w requir been si should	letec						24a. Was	_	utopsy findings available
Vital Records,	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Completed						— autop perfor	sy prior to death?	completion of cause of
ita		BeC	25. Was case referred to medical examiner?					Death (Check only o	ne)	
of \	<u>a</u> = <u>a</u>	ို	1 ☐ Yes 2 ☑ No H	ospital: 1 Inpatient 2 2	ER/Outpation				lence 6 Other (Spe	cify)
o	ding f th. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	at ? ∕es 2.⊟No		low injury occurred	
Division	Attendii er death. rector: A by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number or R	ural Route Number.
	ital or A									<u></u>
	etely fi	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the time restigation, in my op	e, date and p inion, death	place, and due to the o occurred at the time, o	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mont	h, Day, Year)
	10*1		> Muchael	1. Millow	us M.	0 04	1667		11.29	04
ļ	10 th		30. Name and address of person who do	mpleted cause of death (Item  Conneck  32. Tegistrar's Signa	23a) (Type,	Print)	1.	/	Li	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	O WY	1100	Cerap Us	Te jers!	on Ino
	Registr	_	31. Date filed (Month, Day, Year) NOV 29 200	14 Brew	J. pop	erli)				

State of Maryland / Department of Health and Mental Hygie 2e 0 1 4 3

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 25, 10:30 PM November 2004 Morningstar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1208 Wabash Ave. Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Moothe Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F 218-50-4186 57 Director April 29,1947 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examination must be notified at 1 X Yes 2 □ No MD Washington Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 Wabash Ave. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Private School permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles William Cottrill Hattie Mae Domer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George T. Morningstar/Husband 1208 Wabash Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 11/30/2004 4 □ Donation = 5 □ Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mulk Su 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exam Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) the þ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has b irector, page 2 st 1 Tes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 0 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) this After thi Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No after death Director: / investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 24 hours a Euneral Detely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) êç; within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 who completed cause of death (Item\_23a) (Type, Print) Name and address of p 32. Segistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 2004 38734 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Edward Keller MILLS November 22 2004 4:15 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner 7726 McClellan Avenue Boonsboro Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 € M 2 □ F Months Yrs Director 220-58-4227 Sept. 5 1953 Maryland Usual Residence of Decedent be filed within 72 hours eftar deeth with tha Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7726 McClellan Avenue Funeral 21713 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes X ☐ No Specify: ģ Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Correctional Officer State 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be end Mental Pages 1 and 2 should nant of Health end Men Charles C. Mills Doris J. Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Cheryl I. Mills - Wife 7726 McClellan Avenue, Boonsboro, Md. 21713 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment of Important: If eny Injury or pnce. 6 Rose Hill Cemetery 11/27/04 Hagerstown, Maryland 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Omenth Examiner Due to (or as a consequence of): Examine burial-transit the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): usa as attanding p Records, P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to tha causa of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably signed l \$ ata has been signated page 2 should b Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? The law r certificata has 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this complataly filled in by the funeral directoria this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. escribe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation Injury 1 TYes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46443 11/241 04 Μĭ SH Name and eddress of person who completed cause of death (Item 23e) (Type, Print) .; Hagenstown, MD  $\Delta H \Delta$ 0

**DHMH 16 Rev 6/95** 

Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygienen 01.

			1 - State of Maryland / Dep	ertificate of Death		2°004 38735
			Decedent's Name (First, Middle, Last)		2. Date of Dea	ath 3. Time of Death
	Physici		Robert Myers		Novembe	Pay Year 15, 2004 12:18 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		er 15, 2004   12:18 P M
П			2507 Lindell Street	Silver Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs		
ı	Director		506-07-3821 1⊠M 2□F 86 Yrs.	Months Days Hours Min	Dec. 18	
	P .		Usual Residence of Decedent			, IJI/ Nebraska
	how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	e Ma	cto	Maryland Montgomery Siver S	oring		1 ☐ Yes 2 █XNo
	or 28	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Country?
	23a		2507 Lindell Street	20902		USA
	eme eme	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (1) If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
ð	in 72 hours after death with the Maryland "natural", or iteme 23a or 28a-1 show iscless Examinal be notilited at		1 ☐ Never Married 25 Married 11 Yes 2 ☐ No	1 ☐ Yes 2 ☑ No Specify:	ito nicari, etc.)	Black, White, etc.
5-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	TE 163 ZE 140 Specify.		Specify: White
Ž	72	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of wo	orkina	16b. Kind of Business/Industry
2	within lene. than " the Med	E E	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
7	be you			ting Superintende		U.S. Navy
Maryland	be filed htal Hyg ad other evant,	Be	17. Father's Name (First, Middle, Last)		ime (First, Middle,	,
<u> </u>	Men Men Marka Marka	ပ	Hershall Ward Myers		Nola Gla	
ā	2 sh and Is m			ing Address (Street and Number or R		
es es	and lealth m 27 har t			Lindell Street,		oring, MD 20902
Baitimore,	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 Is marked out any Injury or othar traumatic evan once.			matory or other place) NOVE	mber 19	20c. Location - City or Town, State
Ē	Pag men ant: ury		`4 □Donation 5 □Other (Specify) Gate Of Cemet	Heaven ; 20	0.4	Silver Spring, Marylar
<u> </u>	eparit poor ny in		21. Signature of Funeral Service Ligensee	2. Name and Address of Facility Cancis J. Collins	Funeral	Home Inc
ш_	205 g g		50	DO University Blv	d, W, Si]	Lver Spring, MD 20901
			23a. Part 1. Enter the disease, or comblications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arr	est, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	stouchier aulmi		
	/Medical		resulting in death)  Due to (or as a consequence of):	strictive pulmo.	a y	. 26026
	Examiner		I DCheime	Cardiomyopa	thu	
	ס ≒	Examiner	cause. Enter Underlying			
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09/80	ate b hysic the bi	icai	d			
	E 79 8	Medi	IF FEMALE:			
X O D	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	□Ectopic pregnancy		23d. Date of delivery
5	he a	Sic		Other (specify)		Month Day Year
ĭ	d by	P.				
ń	igner be d	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		pacco use contribute to the cause of death?
2	w requir been si should	ted			1 🗆 Ye	es 2 No 3 Probably 4 Unknown
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	The ate h page	PO.			perform	
N I Cal	intific ctor,	Be (	25. Was case referred to medical examiner?	26. Place of De	ath (Check only one	25
>	ysic nis ce dire	2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	nt 3 DOA Other: 4 Nursing H	dome 5√ Reside	ence 6 Other (Specify)
VISION OF	ng Pt ter th		27. Manner of Death 1 → Natural 5 □ Pending   28a. Date of Injury   28b. Time o   (Month, Day Year)   Injury			w injury occurred
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Š	er de recte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number,
2	talo rs aft al DI ed in	Cer			Sky or rown	, otato)
	hou hou uner uner like fill	cai	29a. Certifier Check only (Check n occurred at the time, date and place	and due to the ca	use(s) and manner as stated.	
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ledical	one) and manner stated.	rosagenon, in my opinion, death occu	ared at the time, da	are and place, and due to the cause(s)
	Vith Con	Σ	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, Day, Year)
	+1		7. Bohnston	047928	5	11/14/04
1	140		30. Name and address of person who completed cause of death (Item 23a) (Type,		<u>i</u>	
				gia Avenue, #304,	Silver	Spring, MD 20901
	Sta: Registra		NOV 18 2004	Sparks		

DHMH 17 Rev 1/2001

ate of Maryland / Department of Health and Mental  Certificate of Death	Hygien 2004	38736
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	/Medical		MHK	7 G. 1	110	OK	6				12, 200		9:45 AM
7	Examiner			rive street and number					4b. City, Town, or L			ty of Deeth	
_	•	5. Social Securi		ilitation Sex 7. A		sing (			Burtonsv:			gomer	J
	Funeral Director	244.58	2525	1□M 212F	99	Yrs.		Days	Hours Min.	(Month, D	5, 1905	Blade	place (State or Foreign ntry) es, NC
	yland	10a. State	10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
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	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	10e. Street end	Number				10f. Zip C	Code			10g. Citizen of	Whet Cou	ntry?
	ath w	4203 Co	lumbia Pa	<del></del>			2067				USA		
0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: if item 27 is merked other than "naturel", or items 23s or 28e-f show simply hours or other traumatic event, the Medical Examiner must be notified at once.  To Re Commissed by Eurosca Director	11. Maritel State 1 ☑ Never M 3 ☐ Widowe	us Married 2□ Merried ed 4□Divorced	12. Was Decedent Armed Forces  1  Yes 2 15 If Yes, Give Year or Detes:	?		Was Decede If Yes, specif 1 ☐ Yes 22		ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ice - Am <i>e</i> ri ack, White, <sup>ify:</sup> Whit	etc.
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arylan	Mental Hyg Mental Hyg arked other atic event,	17. Father's Ne	me (First, Middle, La. E. Moore	<u> </u>		10001			18. Mother's Nam Rena Con		Middle, Maiden Surname)		
	2 should and Menia and Men		s Name/Reletionship	(Type, Print)		19b. Maili	ng Address (	Street	and Number or Ru	ral Route Num	ber, City or Town	n, State, Zip	Code)
	1 and 2 Health a em 27 la other trae	Lucille	M. Detto	r / Neice		4203	Columb	oia	Park Rd.	, Pomf	ret, MD	2067	<b>'</b> 5
more,	Pages 1 and of He int: If Item Iry or othe	20a. Method of 1 Description Burial 4 Donetic		Removal from State		lace of Dispo emetery, cree lar Gro			1	Date 1/19/04	20c. Location New Ber	•	
The state of the s	Physician /Medical Examiner	23a Pert1. Ent shock, or Immediate Cau disease or con- resulting in dea	se (Final dition	mplications that cause by one cause on each I		51 n. Do not ent	30 Wis	of dyin		N.W.,	Washing	ton,	D.C. 20016 Approximate Interval Between Onset and Death
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<u> </u>	execuent and and rial-tra	Sequentially lis if eny, leading to cause. Enter U Cause (Disease that initiated ev	t conditions, o immediate		Due to (or	r es a consec	luence of):					1	
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Records,	The law requires that the deeth cert sets has been signed by the ettending page 2 should be detached for use Completed by Physician/N							•		24a. Was	s an autopsy ormed?	av	ere autopsy findings ailable prior to mpletion of cause death?
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	Hospi 24 hou Funer tely fill			Physician: To the best aminer: On the basis o and manner st	f examinat								
	vithin 2 vit		and title of certifier	~ ^ ^			29c. l	License	number		29d. Date sign	ed (Month,	Day, Year)

State Registrar

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31. Date filed (Month, Day, Year) NOV 18 2004 32. Registrer's Signature

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

Marcia Goldmark MD 11906G Darnestown Rd. N. Potomac, MD 20878

D 25348

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 15, McDay 2004 рм 8:12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10024 Brunett Avenue Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Sept. 7, 5. Sociat Security Number 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) **Funeral** Days Hours Min. 12€ M 2 ☐ F 89 Yrs 137-03-0755 1915 South Carolina **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show ust be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 10024 Brunett Avenue 20901 USA death 12. Was Decedent Ever in U.S. Armed Forces? or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Items any injury or other traumatic event, the Medical Exportant page. 11 Marital Status Black. White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ₹ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced WWTT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) United States 12 Postal Service Railway Postal Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Ernest McDay Alma Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances J. McDay/Wife 10024 Brunett Avenue, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Toremation 3 ☐ Removal from State November 17 \* 4 □ Donation 5 □ Other (Specify) 2004 Alexandria, Virginia Crematory 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Will ElSons 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician Dementia 5 Years /Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection 5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examiner physician and the burial-transit death certificate be executed Aortic Stenosis > 5 Years Due to (or as a consequence of) Box 68760 Physician/Medical as for use IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe Congestive Heart Failure, Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2X No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attending Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation To the Hospitel or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NM. MID. D30927 November 17, 2004 1041 white dayse of deal (Item 23a) (Type, Print) silver spring 30. Name and ad Avenue 31. Date filed (MNO) 32. Registrar's Signature State Registra

			1- For Amend Item 25 State of Maryland / Der Pr., C839, 0 Pr.	artment of Health and Mental 7/05dhb rtificate of Death	Hygien 2004 38738	}						
Į.		-8	Decedent's Name (First, Middle, Last)	2. Date of	of Death 3. Time of Death	_						
	Physici /Medic		GLADYS ELLEN MECUM	NOVE.	MBER 15. 2004 3:00 PM	ł						
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death							
			PRINCE GEORGE'S GENERAL HOSPITAL	CHEVERLY	PRINCE GEORGE'S							
F	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min. (Month	n, Day, Year) Country)	ח						
	Director		407-18-6374	FEB	12, 1921   KENTUCKY	_						
	yland		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits							
	e Ma	ctor	MARYLAND PRINCE GEORGE'S GREENBEL	T	1 ₹ Yes 2 □ No	1						
	ith th	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?							
	s 23a		62 F RIDGE ROAD	20770	U.S.A.							
	ler de Item	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - American Indian, Black, White, etc.							
336	within 72 hours after death with the Maryland one. than "natural" or items 23s or 28s-f show the Medical English er mits be notified at	by F	1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No If Yes, Give Year or Dates: 1947-1948	1 ☐ Yes 2 🙀 No Specity:	Specify: WHITE							
21215-0036	72 hours "natural",	ted	15. Decedent's Education   16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry							
21	d within 72 ho piene. r than "natu	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	U. S. FEDERAL							
	등 기를 보고 됐다.			ISTERED NURSE	GOVERNMENT	_						
Maryland	D = D =	Be	17. Father's Name (First, Middle, Last) SYDNEY LEE SMITH	18. Mother's Name (First, Mic	· ·							
Ž	d 2 should be it and Mental I 7 is marked o	5		MENA BROWN  ng Address (Street and Number or Rural Route No								
Ma		1	AT TIPED	3 OLD PROSPECT HILL RD.								
ē,	- 포함된		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date matory or other place)	20c. Location - City or Town, State	_						
Ē	Department Control of the Control of				4 WALDORF, MARYLAND							
Baltimore,			21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HO									
_			The traces	0000 ANNAPOLIS ROAD, BOY	WIE, MD 20715							
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		Interval Between							
			Immediate Cause (Final disease or condition resulting in death)	yndrone	Onset and Death Lours							
			Due to (or as a consequence of):	Cellulitis Cellulitis	DAYS							
**	k.	er	Sequentially list conditions, ff any, leading to immediate b. Due to (or as a consequence of):	ex itis	2/2-13							
	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	es Mellitur	geor							
Ó	an an rial-tr		resulting in death) Last Due to (or as a consequence of):									
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dlcai	d									
9	death certific attending pl	Med	IF FEMALE:			-						
Вох	attenc for us	lan	A Decement at time of death	Ectopic pregnancy	23d. Date of delivery  Month Day Year							
o.	that the de ed by the detached	Physiclan/Me	1 U Yes 2 No 9 Unknown	Other (specify)								
<u>α</u>	s that the ned by the detache	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	nderlying cause given in Part I. 23e. D	Did tobacco use contribute to the cause of death?	7						
rds	w requires that been signed I should be det	ed b	Congestre Heart fuilme	1	☐ Yes 2546 3 ☐ Probably 4 ☐ Unknown	d						
ဝ၁	2 2 2	Completed	Multi organ Fail		Vas an 24b. Were autopsy findings available							
æ	The ate h page	E O	Brent Ca		utopsy prior to completion of cause of death?							
/ita	ucian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death Check or								
of	N S I	2	1		Residence 6 Other (Specify)							
Division of Vital Records,	ding h. After fune	tion		f 28c. Injury at Work?  M 1 □ Yes 2 □ No	be how injury occurred							
/isi	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st		on (Street and Number or Rural Route Number,	-						
ă	elor A s after al Direction	Certification:	4 Homicide building, etc. (Specify)	City or	Town, State)							
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical (	29a Certifier (Check only (Che	n occurred at the time, date and place, and due to	the cause(s) and manner as stated.							
	To the h within 24 To the F complete	Medi	and manner stated.									
	To To	-	29b. Signature and title of certifier	29c. License number 0052865	29d. Date signed (Month, Day, Year)  November 16 th Zoo							
•			30 Name and address of pages it a sometime of		Morenser 16 200	1						
			<ol> <li>Name and address of person who completed cause of death (Item 23a) (Type,</li> <li>K. MICHAEL FIGARO, MD., 3001 HOSPIT.</li> </ol>	·	20785							
	Sta	te	31. Date filed (Month, Day, Year) 32. Projetrar's Signature			-						
	Registra	ar	NOV 1 8 2004 See 5 4	parke								

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Marylan	id / Dep <i>Ce</i>	artment of Fertificate of	lealth and N Death	/lental Hy	giepe Reg. No.	004	38739
	0 ,		1. Decedent's Name (First, Middle, Las	st)				2. Date of De	aath Day	Yeer	3. Time of Death
	Physici: /Medic		Kenneth A.	Mann						5, 2004	3:50 P M
1	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	Location of Death		4c.	County of Deat	h
			Montgomery Hospic	e-Casey House		Rockvil	le			Montgom	ery
	Funeral		5. Social Security Number 6. S	MAN ALLE		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da	rth ay, Year)	9. Birti Co	hplace (State or Foreign untry)
	Director		233-03-9669	8	38 Yrs.			Sept. 6	5, 19	16 Wes	t Virginia
7	* *		Usual Residence of Decedent  10a, State 10b, County	10c. Cit	y, Town or L	ocation					10d. Inside City Limits
100	show	5									1⊈ Yes 2 □ No
4	28a-f	Director	Maryland   Montgome	ery Ro	ckvill	. e 10f. Zip Code			10a Citiz	zen of What Co	untry?
4	ous arier usant with the Marya all, or Itams 23a or 28a-f shov Examiner must be notified at	۵		L		20853					u, .
40	18 23a	Funeral	13317 Oriental S	12. Was Decedent Ever in U	S 13	. Was Decedent of H	ispanic Origin? (Sr	pecify Yes or No		SA 14. Race - Ame	rican Indian.
	Itams Iner mi	S	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White	e, etc.
	or le	by	3	If Yes, Give Year or Dates: 1935-	-68	1 ☐ Yes 2 🖾 No	Specify:			Specify: Wh	ite
	natural, or Itams 23a or 28a-f show rigidical Examiner must be notified at		15. Decedent's Ed	ducation	16a. Dece	edent's Usual Occup	ation		16b. Kir	nd of Business/	Industry
	Man .	ple	(Specify only highest gra	College (1-4or 5+)	life.	e kind of work done DO NOT use retired	di) d)	King			
	tal Hygiene. Id other than " evant, the Me	Completed	12		Ma	ster Chie	f		U.S	. Navy	
2	al H y	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam		, Maiden :	Sumame)	
3	and Ment	2	Harold Mann				Amanda [	)ixon			
_ (	V 10 = 6		19a. tnformant's Name/Relationship (	Type, Print)	19b. Mail	ling Address (Street	and Number or Ru	ral Route Numb	er, City or	Town, State, 2	(ip Code)
	and lealth m 27 har tr		Gary Mann, Sr./S	on		Iris Pla	ce, Rocky	ville, N			Town State
5	nent of He nnt: If its		20a. Method of Disposition  © Burial 2 Cremation 3		cemetery, cre	ematory or other place	Janua	_	200, Lo	cation - City or	rown, State
	ortant: # injury or		*4 □Donation 5 □ Other (Specify			n Nationa tery					Virginia
5	Definit. Fages. Department of Filmportant: If its any injury or of once.		21. Signature of Funeral Service Licer	nsee C D		22. Name and Addre					
	102 6 0		220 Borth Estartha disease or com	diagions that caused the deat		00 Univer				Spring	, MD 2090 Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	in. Do not el	itel the mode of dyli	ig, sucil as caldiac	or respiratory a	iiiesi,		Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Angiosarcom							9 months
	/Medical Examiner			Due to (or as a conseq	(uence of):						
		-F	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	quence of):						
1	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	sician and burial-transit	Exa	resulting in death) Last	C. Due to (or as a conseq	quence of):						
	ohysician the buria	dicai		d							
3		edi									
5	endir endir	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		□Ectopic pregnancy	,		2	3d. Date of del	
ָ ֭֭֭֓֞֝֞֝֞֝	ne att	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o		Other (specify)				Month	Day Year
)	The Taw requires mainte deam cermic tite has been signed by the attending p bage 2 should be detached for use as i	Physician/Med	9 Unknown								
ń	igned be de	by	Part II. Other significant conditions of	contributing to death but not res	sulting in the	underlying cause giv	en in Part I.				the cause of death?
5	pino.	Completed						10	Yes 2	2NO 3   PI	obably 4 Unknown
ָ נ	as be	pje						24a. Was	psy	prior to o	topsy findings available completion of cause of
	certificate has rector, page 2	Con						1 Tes	ormed? 2⊠ No	death?	2□ No
	ertific ector,	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
	this call dire	ု	1 ☐ Yes 2X No	Hospital: 1 Inpatient 2		BILL SILL DOA		ome 5 Res			Hospice Facility
	After I	on:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time tnjury	Wor	k?	28d. Describe	how injury	occurred /	_
2 :	tor: /	cat	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 □ No	29f Location	(Stroot and	d Number of Pi	ral Route Number,
2	after of Dirac	ertification;	4 Homicide determined		fy)	пеет, тастогу, оптсе		City or To	wn, State)	) Addition of MC	A POULD INCLINUEL,
	ours sours  source	O	29a, Certifier Certifying Pt	nysicien: To the best of my kno	owledge des	ath occurred at the fir	me, date and place	and due to the	Cause/el	and manner as	stated.
:	To the hours after death, within 24 hours after death, within 24 hours after death.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medicel Exer	niner: On the basis of examina and manner stated.	ation and/or i	investigation, in my o	ppinion, death occu	rred at the time,	date and	place, and due	to the cause(s)
	vithin To the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	e signed (Monti	n. Day, Year)
			M - C	2000000	N 05	D D	52862		11	1171	2004
3	5+1		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type	Print) Natio	nal Naval	Medica	ıl Ce	nter	~ -
			Kevin Dorrence.								

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 18 2004

Sparks

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F rtificate of	lealth and Death		gien 2 0 0 4 Reg. No.	38740			
	Physici	an	1. Decedent's Name (First, Midd	le, Last)				2. Date of De	Day Year	3. Time of Death			
	/Medic	al	John K.			th Oh Town	-1	Novembe					
	Examin	er	4a. Facility Name (If not institutio Wilson Health	_			or Location of Deat ersburg	:n	4c. County of Dea				
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs			thplace (State or Foreign			
	Director		579-40-6861	1 <b>K</b> ]M 2□F	72 Yrs.	Months Days	Hours Min.	Dec. 11	1931 Was	hington, DC			
	and w		Usual Residence of Decedent  10a. State 10b. County	y	10c. City, Town or L	ocation				10d. Inside City Limits			
	Mary Fied	ţō	Maryland Mont	gomery	Gaither	sburg				1 Karyes 2 □ No			
	or 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?			
	ath wi	raf	13 Cullinan			2087			United St				
36	72 hours after death with the Maryland 'natural', or Itams 23a or 28a-f show dital Exama her must be incitified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Mar  3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Connit				
5-0036	72 hor	Completed	15. Deceder	nt's Education est grade completed)	16a. Dece	edent's Usual Occup a kind of work done	pation	rkina	16b. Kind of Business	,			
2121	han "	mple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retire	d)	, any	Defense Ma	pp <b>i</b> ng			
2	filed w Hygiei thar ti int, th	CO	17. Father's Name (First, Middle,	4 . Last)	Geod	esist	18. Mother's Na	me (First, Middle.	Agency Maiden Sumame)				
au	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	To Be	John K. Mear					0. Payr					
Maryland		-	19a. Informant's Name/Relations	ship (Type, Print)	19b. Mail	ing Address (Street	and Number or R	ural Route Numbe	er, City or Town, State,	Zip Code)			
∑ ″			Joan Mears /	Wife		ullinan D			ırg, Maryla				
Baltimore,			20a. Method of Disposition 1		20b. Place of Disp cemetery, cre Parklawn			Date v. 19,	20c. Location - City or				
턡			' 4 □ Donation 5 □ Other (5	#		2. Name and Addre	1	004 Vol Fune:	Rockville,	Maryland			
ä	Der Imp		1 July C	- W		E. Deer			ersburg, MI	20877			
			23a. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Constraints and Disease and										
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Acc	lepuls	2652	asyl	mile	662162	40 minutes			
П	Examiner				a unsequence of):		J						
	D ==	ner	Sequentially list conditions, It any, leading to in rediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or se	a consequence of):								
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of);								
68760,	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transif			d									
_	tificate ig phy as the	ledicai		u.					Т				
Вох	th cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □Live birth		□Ectopic pregnancy	y		23d. Date of de Month	livery Day Year			
-	he dez the at	Physician/M	1 Yes 2 No	4□ Pregnant a 9□ Unknown	t time of death 5	Other (specify) _			Worth	Day			
P.0	The law requires that the death certit ate has been signed by the attending page 2 should be delached for use a	by Ph	Part II. Other significent conditi					23e. Did to	obacco use contribute to	o the cause of death?			
Records,	w requires been sign should be	ed b	Laronarya	"elenger	uese.	abeter	v11.	1□1	res 2 ⊠No 3 □ P	robably 4 Unknown			
eco	e law re has bed je 2 sho	Completed	Syperten	seon Histo	ry g coco	nary 0	y-pass	24a. Was		utopsy findings available completion of cause of			
<u>س</u>	Physician: The lithis certificate har all director, page	Con	4 centrical	ne seplore	ement.	ost-faci	-6		rmed? death? 2 No 1 ☐ Yes	2 □ No			
Vital	sician: Th certificate rector, pag	o Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:		at 2000 Oth		ath (Check only o					
o	Attending Physician: r death. sctor: After this certification the funeral director.	1-	27. Manner of Death	1 ☐ Inpati	ry 28b. Time o	III 3LI DOA	4 Nursing F		dence 6 Other (Spe	icify)			
ion	anding ath. or: Afte	atio	E	tigation	ay Year) Injury		Yes 2 □ No						
Division of	or Atter frer de Siracte in by th	Certification:	3 Suicide 6 Could 4 Homicide determ	mined   288. Place of In	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,			
	spital ours a naral C	al Ce	29a. Certifier 1 Certifyi	ing Physician: To the best	of my knowledge dea	th occurred at the tir	me, date and place	a, and due to the	cause(s) and manner as	s stated.			
	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the funer	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner st	of examination and/or in	nvestigation, in my o	ppinion, death occi	urred at the time,	date and place, and due	to the cause(s)			
	To the To the comp	ž	29b. Signature and title of certifie	ar ,	(	29c. Licens	se number		29d. Date signed (Mont	th, Day, Year)			
	10		WHRaker	Duscha	acqual	100	4/15		Virember	16,2009			
	,		30. Name and address of person H. KCBEKT BIKK. 31. Date filed (Month, Day, Year	who completed cause of a	death (Item 3a) (Type	Print) 201 (	HERS B	1126, A	NUE 2087	7			
	Sta		31. Date filed (Month, Day, Year	9 2004 32. Registr	rar's Signature	Some	61						
	Registr	ar	MOA T	U 2004		17	र र						

			1 - State RegistrarAMEND#1per MD11	State of Maryla 23/04,BW,McCo	nd / Depa <i>Cer</i>	artment of H rtificate of I	lealth and I Death		gie2e0 0 4	38741
	Dhusisi		1. Decedent's Name (First, Middle, Last,	)				2. Date of De		3. Time of Death
	Physici /Medio		Linda Marie McCle	af AKA Lin	da Cann	on McCle	af			04 12:04 P M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of De	eath
			Gilchrist Center-H			Baltimo	ore If Under 24 Hrs.	10000	Baltimo	
	Funeral Director			1M 059 E	. last birthday) 55 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
			213-48-0815 Usual Residence of Decedent		33			April 2	1949 Wa	shington, DC
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Howard	Da	ayton					1 ☐ Yes 2 🛣 No
	iih th or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w		5217 Kalmia Drive			21036			USA	
	er de Items	Funeral		12. Was Decedent Ever in t Amed Forces?	J.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S) n, Mexican, Puert	pecify Yes or No Rican, etc.)	14. Race - Av Black, W	merican Indian, hite, etc.
36	wihin 72 hours after death with the Maryland iene. rthan "naturel", or Items 23a or 28s-f ehow tre Medical Exantrar must be notified at	by F	1 ☐ Never Married 2/☐XMarried 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 <b>/K</b> )XNo If Yes, Give Year or Dates:	1	l□Yes 21€ No	Specify:		Specify: Wh	nite
Ö	72 hou natura	per	15. Decedent's Edu	cation		ient's Usual Occupa		-	16b. Kind of Busines	ss/Industry
215	within 73 ene. than "n	ple	(Specify only highest grad	e completed) College (1-4or 5+)	(Give life. L	kind of work done of DO NOT use retired	during most of won ()	-	U.S. Gover	
21		Completed	12		Sta	ff Assist	ant		Nat I Institu	ites of Health
Maryland 21215-0036	be filed ntal Hygie of other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ie (First, Middle,	, Maiden Sumame)	
yla	1 end 2 should Health and Mer tem 27 is marke other traumatic	ပ္	John Walter Cann					Mary Me	<del></del>	
Nar		1 4	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	ig Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town, State	, Zip Code)
			John R. McCleaf, 20a. Method of Disposition	20h	Place of Disno	Kalmia Dr sition <i>(Name of</i>		ton, MD	21036 20c. Location - City	or Town State
Jor	Pages nent of the		1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cren	natory or other plac is	e) Nove	mber 19		
Baltimore,	it Parimer		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fuheral Service Logis		Cemet	erv . Name and Addres	; 20	04	Clarksvill	e, Maryland
Ba	permit Pages Department of Importent: If II any injury or o		Nobert /	Sile	Fr	ancis J.	Collins	Funeral . West,	Home Inc. Silver Sp	oring, MD 20901
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dea ne cause on each line.	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ai	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metastania	- 600	ast Car	NO2			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						
ì	LAdillinei	_	Sequentially list conditions,	D						
	ped Isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
_	xecut and II-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
9	cate be executed physicien and the burial-transit	aE								
68760,		edicai		J						
Box	eath certif attending for use a	an/M	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregn					23d. Date of d	lelivery
	that the death cert ed by the attendin detached for use	icia	in the past 12 months? 1 ☐ Yes 2 <b>A</b> No	1 Live birth 2 Fet 4 Pregnant at time of		Ectopic pregnancy Other <i>(specify)</i>			Month	Day Year
0	t the by th ache	Physicia	9 Unknown	9□ Unknown						
ds, P	w requires that the sbeen signed by the should be detache	by	Part II. Other significant conditions con	ntributing to death but not re-	sulting in the ur	nderlying cause give	en in Part I.			to the cause of death?  Probably 4 Munknown
of Vital Record	> 0 0	ompieted						24a. Was	an 24b. Were	autopsy findings available
Re	9 - 9	duc							prior to	completion of cause of
ta	iclan: Th certificate ector, pag	e C	25. Was case referred to medical				26. Place of Dear	1 ☐ Yes	2. A∏No 1 □ Ye	es 2 No
Ž	8 5	To B	examiner? 1 Tes 2 No	lospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	\r*	ome 5 Resid	- 17	pecify) VESDICE
	ding Phy th. After thi funeral o		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at		now injury ocurred	" Total
0	Attending r death. ector: After by the fune	atic	2 Accident investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2□No			
Division	l or Attendente of the death of the Charter of the	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At Inbuilding, etc. (Speci	nome, farm, stre ify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
	To the Hospital or Attentwithin 24 hours effer deation to the Funerel Director: completely filled in by the	edical C	Check only '2 Medical Exami	sician: To the best of my kn ner: On the basis of examin	owledge, death	occurred at the tim	ne, date and place, pinion, death occur	and due to the red at the time.	cause(s) and manner date and place, and de	as stated.
	To the within 2. To the I complete	Med	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signed (Mo	
)	F 3 F 8		Maleran	li		DS	8303			
	12		30. Name and address of person who co	empleted cause of death (lie	m_23a) (Type, I	Primo Caral	. 0/	0	vovember	0(2)
	1		ATTION CHARLE	32. Begistrar's Sign	0 ( N-	Wash	es st	Baltu	nore MD	21204
	Sta Registr		31. Date filed (Month, Day, Year)	4 Jewa	G	doork	/			

Mc Cleaf, Linda UliTloy @lapm

Mark McKinney 04-7702 DOS

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	DOS		1 - For Unpend I Registrar	tem 25tate 7	of Maryla	nd Dee Ce	a <b>ngga</b> t p <u>5</u> b rtificate of	leath and Death		giene 0 C	) 4	38742
	Physici	an	1. Decedent's Name (First, Mid						2. Date of Dea Month	Day	Year	3. Time of Death
	/Media		MARK BRYAN	MCKINNEY					Novemb		2004	1848p м
2	Examir	ner	4a. Facility Name (If not institut North Arunde				Glen Bu	or Location of Deatl	1	Anne		ioi.
2	Funeral		5. Social Security Number	6. Sex		i. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	1		lace (State or Foreign
	Director		265-83-9754	1 XM 2 ☐ F	40	Yrs.	Months Days	Hours Min.	May 28	, 1964	Mary	land
-di	tand ow		Usual Residence of Decedent  10a. State 10b. Coun	ity	10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	ith the Marylar or 28e-f show	tor	VA Lo	uisa	В	umpass						1 ☐ Yes 2 No
	or 28	Olre	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	s 23a	eral	1536 Signboa		edent Ever in l	10 42	23024			USA	A = 2	and the district of the second
920	72 hours atter death with the Maryland naturel', or items 23a or 28e-f show disal Example or untilled at	by Funeral Director	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorce	Armed F arried 1 ☐ Yes If Yes G	orces? 2 XNo ive		was Decedent of F If Yes, specify Cub.	dispanic Origin? (S an, Mexican, Puert Specify:	pecity Yes of No- o Rican, etc.)		ce - Americ ck, White, y: Whi	etc.
5-0	72 h	etec		ent's Education nest grade completed,		(Give	dent's Usual Occup	during most of wor	king	16b. Kind of B	usiness/In	dustry
21215-0036	led within ygiene. ner then '	Completed	Elementary/Secondary (0-12		1-4or 5+)	Plur	nber			Self		yed
Maryland		To Be	17. Father's Name (First, Middle Walter Egber		Jr.				Yvonne N		ne)	
			19a. Informant's Name/Relatio				ng Address <i>(Street</i> Avondale	and Number or Ru Drive	ral Route Number Bowie, M		_	Code)
Baltimore,		12.	20a. Method of Disposition 1		State Mc	Place of Dispo cometery, crei Kinney	sition (Name of matory or other plan Family C	emetery	Date 2/5/2004	20c. Location - Bumpa		
Balt			21. Signature of Foneral Service	e Licensee			Name and Address		bert E.	Evans F e, MD	unera 20715	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that ist only one cause on	caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		tic int		ion					Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conse	quence of):						
	execute n and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	quence of):						
38760,	icate be executed physician and s the burial-transit	dlcal		d								
.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregr birth 2 Fet nant at time of nown	al death 3	Ectopic pregnancy Other (specify)	/			te of delive	ory Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant condi	tions contributing to c	leath but not re	sulting in the u	nderlying cause giv	ren in Part I.		bacco use cont es 2□No		e cause of death?
I Records,		Completed							24a. Was a autops perform	SY .	prior to cor leath?	psy findings available inpletion of cause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?	-			0.4		th (Check only on	18)		
of	Phys	7	1 X Yes 2 ☐ No 27. Manner of Death	28a, Date	of Injury	ER/Outpatier 28b. Time of		4   I lant 2 lind Li	ome 5 Reside			
ion	Attending Phr r death. ector: After th by the tuneral	atlon	1 Natural 5 Pend	ding Found	th, Day Year) -04	Injury	Wor	k? Yes 2 <b>X</b> No	200. 2000/100 110	on injury cooding	uii	K
Division	or Attendi	Certification;	3 ☐ Suicide 6 Coul	d not be mined 28e. Place build	e of Injury - At I	nome, farm, str ify)	eet, factory, office		28f. Location (St City or Town	reet and Numb	er or Rura	Route Number, ritage Hill
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certify (Check only of Medic	ring Physicien: To the	e best of my kn pasis of examin	owledge, death	n occurred at the tir restigation, in my o	ne, date and place pinion, death occu	and due to the ca	ause(s) and ma	inner as st	ated.
	To the within 2 To the complet	Me	29b. Signature and title of certif		inor states.		29c. Licens			9d. Date signe		
			30. Same and addless of person	on who completed cau	se of death (Ite	m 23a) (Type.	OCMI			December		2004
			J-CRON	Locke	(no		111 Peni	Street,	Baltimo	re MD 2	21201	
	Sta Registr		31. Date filed (Month, Day, Yea	2 2004	egistrar's Sign	A A	South .					

State of Maryland / Department of Health and Mental Hygie 20 0

Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Robert George Nash 220 PM /Medical Tovonba 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Director 137-12-7663 83 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir then "naturel", or items 23e or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1X Yes 2 □ No Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1250 Crescent Road 21742 death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel," or ite, any injury or other treumatic event 1X Yes 2 1 Never Married 2X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 th College (1-4or 5+) Quality Control Officer Truck Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Glenn Nash Jesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Bettie Jane Nash / Wife</u> 1250 Crescent Road Hajerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium Nov. 24, 2004 Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac St. Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Box 68760 Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Po Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpatient 3 DOA After the funeral 27. M. nor of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending within 24 hours after death. To the Funerel Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 60228 3H-12+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12821 31. Date filed (Month, Day, Year)
NOV 29 32. Degistrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene () 1 - State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Joseph Edward Norton, Sr. November 17, 2004 ам /Medical 8:20 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health Care-Silver Spring Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□F 577-07-1371 91 Yrs. June 29, Director 1913 Washington, Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Interportant: If item 27 is marked other then "neturel", or items 23a or 28e-f show my injury or other treumatic event, the Medical Evanthar must be notified at once. 1 ☐ Yes 2 XNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1506 Gleason Street 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 🖾 No 1 Never Married 2 Married Baltimore. Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Shipping Manager Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Claude Nelson Norton Maire Louise Reynolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Eleanor Norton/Wife 1506 Gleason Street, Silver Spring, MD 20902 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State November 17 1 ☐ Burial 2XX remation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Alexandria, Virginia \_22. Name, and Address of Facility
Francis J. Collins Funeral Home Inc 21. Signature V Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a, Part Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Congestive Heart Failure disease or condition resulting in death) Years /Medical Due to (or as a consequence of): **Examiner** Cardiomyopathy Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, ign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Minknown Sepsis, Urinary Tract Infection Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2□ No 1 Yes Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fun completely 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) ma D32332 November 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, M.D. 9801 Georgia Avenue, #220, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 19 2004 auks Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 L Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** NOVEMBER 2004 12:23 P HARRIET 17, POSNER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🕅 F Yrs. 10/12/1920 099-12-8712 84 NEW YORK Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show in then "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2X No Director MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with and Menial Hygiene. Is marked other then "naturel", or Items 23a or ? 3310 N. LEISURE WORLD BLVD. #421 20906 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 4 injury or other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked o LENA 2 ROGOFF NATHAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERTA MILLER/DAUGHTER 11019 THISTLEBROOK CT., COLUMBIA, MD 21044 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 
☐ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) MT. LEBANON CEMETERY 11/19/2004 ADELPHI, MARYLAND 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 'n amarda 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 15 YEARS **Physician** CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 15 YEARS AORTIC STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the death certificate be executed use as the burial-transit 1 MONTH ANEMIA that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown hed by The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy has certificate 1 Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) <sup>L</sup> this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 27. Manner of Death 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifie November, 17, 2004 10 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Blud, Rockville, MD 20852 6116 Executive 32. Begistrar's Signature 31. Date liled NOV Year) State 8 2004 Registra

ORIGINAL

DHMH 17 Rev 1/2001

			1- For State of Maryland Registrar		artment of F			iene 2004	38747
I	° Physic	an	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	/Medi	cal	WILLIAM PAUL					R 10, 2004	5:30 A M
<i>B</i> .	Examir	ier	4a. Facility Name (If not institution, give street and number) 5801 NICHOLSON LANE, APT. 1435			r Location of Death		4c. County of Deat	
**	Funeral	* *	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	ETHESDA If Under 24 Hrs.	8. Date of Birth	MONTGOM 9. Birt	
L	Director		578-38-4929 1X M 2□F 89	Yrs.	Months Days	Hours   Min.	JAN. 12	, 1915MASS	hplace (State or Foreign untry) ACHUSETTS
	and and		Usual Residence of Decedent           10a. State         10b. County         10c. City, T	own or Lo	cation				10d. Inside City Limits
	Maryl	tor	MARYLAND MONTGOMERY N. BE						1 X Yes 2 □ No
	n the	Director	10e. Street and Number	TUES	10f. Zip Code		10	g. Citizen of What Co	untry?
	23s c		5801 NICHOLSON LANE, APT. 1435		20	0852		U.S.A.	•
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V		ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	rican Indian,
36	rs afte	by F	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never 2 Never NAVY 1 Never Married 2 Never Navy 2		☐Yes 2 <b>X</b> No			Specify: WH	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23s or 28e-f show ite Medical Examiner must be notified at		15. Decedent's Education 1	6a. Decec	ent's Usual Occup	ation		6b. Kind of Business/I	
215	thin 7 e. en "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	kind of work done of OO NOT use retired	during most of working ()	9		
21	filed wi Hygien other th		12 M	IERCH/	ANT			GROCER	
Maryland	ntal H ed oti	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	First, Middle, M	faiden Surname)	
Ž	should and Men e marke umetic	ြ	JOSEPH PAUL  19a. Informant's Name/Relationship (Type, Print)	19h Mailin		DORA	Pouto Number	WOLF City or Town, State, Z	To Code by
	and 2:							N. BETHES	
altimore,	of He of He fitem		20a. Method of Disposition 20b. Place	of Dispos	sition (Name of place	Da		Oc. Location - City or 1	
Ĕ	Pages ment of lent: If it			EBAN(	ON CEMETE	RY 11/12	<sup>2004</sup> A	DELPHI, MA	ARYLAND
Bail	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturet", or items 23s or 28e-f show misportant: If item 27 is marked other than "neturet", or items 23s or 28e-f show injuryed other treumetic event, the Madical Examinat must be notified at annote.		21. Signature of Funeral Service Licensee	22. EI	Name and Addres	ss of Facility EL FUNERAL	DIRECT	TON. INC.	
		_	23a Part Filter the disease or complications that raused the least of	1.0	JOI ROCKV	ILLE PIKE,	ROCKVI	LLE, MD 20	
			23a. Part1. Enter the disease, or complications that caused the eath. E shock, or heart failure. List only one cause on each line.	o not one	ine mode or dying	g, such as cardiac of	respiratory arres	st,	Approximate Interval Between Onset and Death
20	Fnysician /Medical		disease or condition resulting in death)  PNEUMONIA  Due to (or as a consequence)	ce of):				2	2 MONTHS
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	p ti	iner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury	>e of):					
_	and J-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C						
8760	cate be executed physician and the burial-transit	dlcal E	330 10 (0) 43 4 00 100 900 11						
189	death certificate be executed e attending physician and id for use as the burial-transit	a)	d						
ŏ	eath certific attending p	hysiclan/M	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  1 □ Live birth 2 □ Fetal dea		Ectopic pregnancy			23d. Date of deliv	/ery
O. B	the att	sicla	in the past 12 months?  1   Yes   2   No		Other (specify)			Month	Day Year
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Records,	requires that the een signed by th hould be detache	d by	ARTERIOSCLEROTIC CARDIOVASCULAR D			stilltratitt.		**	bably 4 Unknown
S	> 40 00	lete	CEREBRAL VASCULAR ACCIDENTS				24a. Was an		opsy findings available
	The law rate has b page 2 sl	Completed	ODKEDICE VADOUBAL ACCIDENTS				autopsy performe	prior to co	ompletion of cause of
Vital		BeC	25. Was case referred to medical examiner?			26. Place of Death (			2□ No
ot	Physicien: this certific ral director,	L L	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3□ DOA Othe			ce 6 Other (Speci	fy)
on C	ding P h. After t funera	iuo !	1 XNatural 5 ☐ Pending (Month, Day Year)	Time of Injury	28c. Injury Work		d. Describe how	injury occurred	
Division	or Attendi after death. Director: A in by the fu	ficat	2 Accident investigation 3 Suicide 6 Solution to be 28e. Place of Injury - At home	farm stre		′es 2 □No	Location (Stre	et and Number or Run	of Pauta Alumbas
2	el or At	Certification;	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	raini, stroi	ot, radiory, arrive	20	City or Town,	State)	si riodite ivuinber,
	To the Hospitel or Attending within 24 hours after death.  To the Sunerel Director: After completely filled in by the fune.		29a. Certifier (Check only 2   Medical Examiner: On the basis of examination	ge, death	occurred at the time	e, date and place, and	d due to the cau	se(s) and manner as s	stated.
	To the H within 24 To the 5 complete	Medical	one) and manner stated.	and/or inve			at the time, date	e and place, and due t	the cause(s)
		<	29b. Signature and title of certifier	7	29c. License	number	290	I. Date signed (Month,	Day, Year)
7	12		30. Name and address of person who completed cause of death (Item 23a	\ CT:	D1381	18	NO	OVEMBER 10	, 2004
			GARY FISHER, M.D., 5530 WISCONSIN		•	. 730. CHE	ЛУ СПЛСТ	7 MD 2001	-
	Sta	te .	31. Date filed (Month, Day, Year) 32. Registrar's Signature				VI CHASI	10 ZUST	,
48	Registra	ar	NOV 18 2004 Janes	9	Sparks	/			

			1 - For Amend Item :	State of Mary 23a per Dr.	land / Dei , G838 ,是	partment of	Health a	and Mei		gien <b>e</b> ()	04	38748
	Physici	an	1. Decedent's Name (First, Middle, Last,					2.	Date of Dea	ath Day	Year	3. Time of Death
<b>)</b>	/Medi		TONY C.	PARROTTA					11	22	2004	1:37 PM
1	Examir	er	4a. Facility Name (If not institution, give	street and number)	C CONTRI	4b. City, Town			0		nty of Death	
	1	. *	Social Security Number 6. S		yrs. last birthda			24 Hrs. 8.			S.A.	100
	Funeral Director			M 2□F	86 Yrs.	Months Da		Min.	Date of Birt	v, Year)	Penr	place (State or Foreign ntry) ISylvania
9.40	4		Usual Residence of Decedent						9/26	(18		7 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
	nylan how	_	10a. State 10b. County	ľ	: City, Town or	1						10d. Inside City Limits
	Ba-f e	Director	MD Harford		ABERDEG	77	<u></u>					1 TYes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip Cod	Ð			10g. Citizen o	f What Cou	ntry?
	a 23e	rai	631 Westwood		- 110	2:10				U.S.A		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show programs: If Item 27 is marked other than "natural", or Items 23s or 28s-f show appring or other traumatic event, Ite Madical Examinar must be notified at once.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 X es 2 No If Yes, Give Year or Dates: WW.		3. Was Decedent of If Yes, specify C			/ Yes or No- an, etc.)	Į.	ace - Americack, White, with:	etc.
ŏ	2 hou	ted	15. Decedent's Edu	cation	16a. Dec	edent's Usual Oc	cupation			16b. Kind of	Business/In	dustry
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ğ	be fill d off	Be	17. Father's Name (First, Middle, Last)	1 -						Maiden Suma	ame)	
<u> </u>	should nd Men marke umatic	2	Daniel Parrot					ncesca				
Z	d 2'st th and 7 is n traun		19a. Informant's Name/Relationship (Ty Mary Celine Parrot	•		iling Address <i>(Stre</i> Westwood						0 Code) 1001
ē,	1 an Heal tem 2		20a. Method of Disposition	20	b. Place of Dis	position (Name of		Date	-	20c. Location		
פֿב	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ P 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State M	t. Erin	ematory or other p	elace) Z 1	1/27/0	)4			ace, MD
ŧ	permit. P Departme Importan eny injur		21. Signature of Funeral Service License	90		22_Name and Add			-			200, 120
ñ	Page 2		Vaua ( 2	ellmar	7	Tarring- Aberdee	-Cargo 1, Mary	Tunera Land	12100T	e 3399 <sup>A</sup>	•	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the c								Approximate
	Physician		Immediate Cause (Final disease or condition	HEMORR		_						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a con	1 7	Left Pu		v Arte	rv Te	ar	-	
ď.	Examiner		Sequentially list conditions.	wer no	MEX	ARTER	-	-				
	Sit 3d	iner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):							
	and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a con	sequence of):							
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687	ficate physics the	adic										
P.O. Box	law requires that the death centificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	☐Ectopic pregnal			······································	1	ate of delive	ory Day Year
J.	that	by Pr	Part II. Other significant conditions con	tributing to death but not	resulting in the	underlying cause	given in Part I.		23e. Did to	bacco use cor	ntribute to th	ne cause of death?
Vital Records,	quire; in sig uld be	g pe	LUNG CANCER						1嵐Y	es 2 No	3 🗆 Prob	ably 4 Unknown
ပ္ပ	law require as been si 2 should b	Completed							24a. Was a		Were auto	psy findings available
ř	9 - 9	E							autops perfor	med?	death?	npletion of cause of 2□ No
<u>ta</u>	iician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place	of Death Ci			1 0 165	20 NO
<u>o</u>	d S	10	1 Yes 2 No		2 ER/Outpatio	ent 3 DOA	Other: 4 🗆 Nu	rsing Home	5 🗆 Reside	ence 6 🗆 Ot	ther (Specify	y)
ב	Jing Pt J. After th funeral	on:	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	of 28c. In	jury at fork?	28d.	Describe h	ow injury occu	rred	
<u>s</u>		cati	2 Accident investigation 3 Suicide 6 Could not be				□Yes 2□l	_				
=	i Pite	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, s ecify)	street, factory, offic	е		Location (Si City or Town		iber or Rura	l Route Number,
	To the Hospital within 24 hours and to the Funaral completely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge des	th occurred at the	time date se	d signs, and	due to the e			
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Examinations)	ar: On the basis of exam	nination and/or i	nvestigation, in my	opinion, deat	th occurred a	t the time, d	ate and place	, and due to	the cause(s)
	Fo the Complex complex	Me	29b. Signature and title of certifier	7		29c. Lice	nse number		2	9d. Date sign	ed (Month, i	Day, Year)
	1		> Latel	MD			D5252	8		- 11	/22/-	9
1	011	ļ	30. Name and address of person who co			Print)				,		
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DHA	4H 17 Pay 1/2		DEC 0 7 2004	Agent	A 1	goods!						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie Pen [] 38749 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year CATHERINE RIEGERT NOV 6 2004 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 26, 2004 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 ☐ M 2 🛣 Days 12 Hours Min. Yrs. Director N/A Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🏖 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with or itams 23a or 6311 Summercrest Drive 21045 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ρ 3 Widowed 4 Divorced Specify: White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7/ h and Mental Hygiene." n 7 Is markad othar than "n Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. Riegert Karen Provost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is n any injury or other traum odce. James A. Riegert/Father 6311 Summercrest Drive Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Arlington Nat'l Cem. 11-30-2004 Arlington, VA ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) EXTREME PREMATURITY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and tor use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 😾 No 9 ☐ Unknown the 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 2X No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1X Natural s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral I To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) A75511 (CA) s of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER JASON D. HIGGINSON LTMC USN BETHESDA MD 20889-5600 31. Date filed (Month DEC Vear 32. Registrar's Signature State ooks! Registrar

04 - 7334

1 - State Registrar

State of Maryland / Department of Health and Mental Hygiene a state of Maryland / Department of Health and Mental Hygiene

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38750

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 14,2004 9:57a ANNIE HOWARD WALROND /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Hours 1 M XXF 22, 1936 VIRGINIA 68 224 42 0782 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State r items 23a or 28a-f show direr ount be notified at XX Yes 2 No Directo UPPER MARLBORO MARYLAND PRINCE GEORGES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number i be filed within 72 hours after death wil ntal Hygiene. 3d other than "natural", or items 23e c event, the Modical Exzoluter out the 20774 UNITED STATES 2931 CHESTER GROVE ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK ¥X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2YRS: WAITRESS PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fil Health and Mental H tem 27 Is marked otl BEULAH JOHNSON JOHN HALL 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2931 CHESTER GROVE RD. UPPER MARLBORO, MD 20774 or other tra DIANN HOWARD / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott xXBurial 2 ☐ Cremation 3 ☐ Removal from State ZION CHURCH CEMETERY 11/20/2004 KINSALE, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MD/FISHER FUNERAL HOME 21. Signature of Fymeral Service Licensee OLDHAMS, VA SUITLAND, MD 4308 SUITLAND ROAD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) thromboembolism Physician Pulmonar /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Y Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Tahrillah Al OCME NOVEMBER 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABLUCE AH ACI 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State

Registrar

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			For State Registrar	State of Maryland / Dep Ce	artment of Health and M rtificate of Death		2004	38751		
I	Physici		1. Decedent's Name (First, Middle, La THELMA L.	WINDHAM		2. Date of Death Month	Day Year	3. Time of Death 4:45 P M		
	/Medio Examin		4a. Facility Name (If not institution, given	re street and number)	4b. City, Town, or Location of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4c. County of Dea	th		
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	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation	1141 . 22	1 1 0 0 0	10d. Inside City Limits		
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	h with th	al Dire	10e. Street and Number 1102 Colony R	idge Road	101. Zip Code 2 1 1 1 3	10g	Citizen of What Co	•		
336	ages 1 and 2 should be filled within 72 hours after death with the Maryland ent of Health and Mental Hygiene.  11: If itam 27 is marked other than "natural", or items 23a or 28a-f show y octother traumatic evant, it a Medical Exameration is its its libed at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi			
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	t and 2 tealth a tm 27 is		Nancy McGinne 20a. Method of Disposition	ss/Daughter 177	708 Shady Mill F		·			
Baltimore,	permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is rr any injury ocother traum		1 Selection of Disposition  1 Selection 2 □ Cremation 3 □  1 □ Cremation 3 □ Other (Special Content of Conten	Removal from State cemetery, cre	matory or other place)  Grove Cem. 11/2		c. Location - City or Voodfie1			
	rnysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	polications that caused the death. Do not en		Laytons	sville,			
,	icate be executed physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):  Due to (or as a consequence of):  d.				3 weeks		
.O. Box 6	ne death certif the attending hed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	livery Day Year		
Records, P.	w requires that the been signed by should be detact	by	Part II. Other significant conditions	contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac		o the cause of death?		
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Division	i i i	Certification;	3 Suicide 6 Could not be determined		reet, factory, office	8f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,		
	To the Hospital within 24 hours a To tha Funaral Completely filled	edical (	29a. Certifier (Check only one)	nysicien: To the best of my knowledge, deat miner: On the basis of examination and/or ir and manner stated.	th occurred at the time, date and place, a livestigation, in my opinion, death occurre	nd due to the caus d at the time, dato	e(s) and manner as and place, and due	stated. to the cause(s)		
)	To the within 2 To that complet	M	29b. Signature and title of certifier  Mathew K	leno	29c. License number D 41 57 5		Date signed (Mont	* '		

State

Registrar

305 HOSPITAL DRIVE, STE305. GLEN BURNIE, MD 21061
32. Registrar's Signature

porks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW PARK, M.D.,
31. Date filed (Month, Day, Year)
NOV 18 2004

State of Maryland / Department of Health and Mental Hygiese 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 12, 2004 MIRIAM WEINSTOCK 7:25 P M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 7401 BRADLEY BOULEVARD MONTGOMERY **BETHESDA** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, JANUARY Birthplace (State or Foreign Country)
 NEW YORK **Funeral** Months Days Hours Min. 1 □ M 2 Ū F Yrs. Director 057-07-2025 94 1910 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show treumatic event, the Madical Exercities must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND MONTGOMERY **BETHESDA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7401 BRADLEY BOULEVARD 20817 or Items 23a UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced naturel', WHITE eted b 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. other than "n Compl Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit.
Department of Health and Mental Hygiene
Importent: If item 27 is marked other tha
any injury or other treumatic event, II.\*/ SECRETARY FINANCIAL SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **JACOB** WEINSTOCK FANNY POHL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK ROBINSON, NEPHEW 11314 ROLLING HOUSE ROAD, ROCKVILLE, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 【XRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORY 11/19/2004 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licenses 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. todath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Envsician STROKE disease or condition resulting in death) SUDDEN /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð pe ALZHEIMER'S DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLITUS COLON NEOPLASM certificate 2[] No 1 Yas Hospital or Attending Physicien: 25. Was case referred to medical director 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 X Residence 6 Other (Specify) P 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D32332 NOVEMBER 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH KUMAR GUPTA, M.D., 9801 GEORGIA AVENUE, #220 SILVER SPRING, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature VON 18 2004 Registrar Darks

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	HIRE	٦	22 Part Enter t	the disease, or	complica	ations # at o	caused	the death.	Do not e	nter the mo	de of dy	ring, such as cardia	c or respiratory	arrest,		Approx Interval	imate i Between
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	Hospital or Attending F     24 hours after death.     Funeral Director: After letaly filled in by the funeral control of the funeral	dicai	29a. Certifier (Check only	1☐ Certifyin	ng Physic Examine	r: On the b	esis of	exeminatio	edge, dee n and/or	oth occurred investigation	d at the on, in my	time, date end place opinion, death occ	e, and due to thurred at the time	e cause(s) an e, date end pla	d manne ace, end du	s stated. e to the cau	use(s)
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State Registrar nd tille of certifier

eddress of person who completed cause of death (Item 23e) (Type, Print)

29b. Signatur

29c. License number

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year) NOV • 21,2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wilson enize 2004 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Square Bo Ho Rose 40 111066 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 16-64-8245 Days 1 M 2 F Months Hours Min. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 1 ☐ Yes 2 ☑ No **Funeral Director** DoRC Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rhodesda 42 le-Vienna Rd 6 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. the Medical Examiner 1 Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No ō 1 Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Supervi Son Board (
18. Mother's Name (First, Middle, Maiden Sumame) Board of Education  $I \alpha$ anould be filt. Ith and Mental Hyd. 7 Is mark other traumatic event, Maryland 17. Father's Name (First, Middle, Last) ISaac Waller 1 and 2 should DaRIS  $\alpha$ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21869 t of Health a 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town State sregor1 Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State ŏ permit. Page Department of Important: If any injury or once. Cambridge, MD Mid Shore Cremation 11-23-04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HENRY Funeral Home, P.A.
510 Washington St. Cambr anelle Cambridge, MD, 21613 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Shoule /Medical Due to (or as a consequence of): Examiner Choleyskh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 2 No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural after death.

I Director: Ald in by the fu 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide / filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 29b. Signature and title of certifier

State Registrar

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	Funeral Director		234-30-8258	Sex 1 □ M 25€ F 7. Ag	ge (In yrs. last birthday 87 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb • 23,	year 9. Birt 1917 Ric	nplace (State or Foreign untry) hwood, WV
	land SW		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	the Mary 28e-f sh	ector	MD Montg	omery	Rockvi				On Cinima of Miles On	1 No 2 □ No
	23a or	al Dir	9701 Veirs Driv	е		10f. Zip Code 2085	0		0g. Citizen of What Co USA	untry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
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	nd 2 shou alth and N 27 Is ma		19a. Informant's Name/Relationship Peter C. Brunett			ing Address <i>(Street a</i> ) Allistai			City or Town, State, Z Salem NC 2	
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe	1. 24	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5 Other (Special	Removal from State	20b. Place of Disp cemetery, cre Queen of H	osition (Name of matory or other place Baven Cemete	ery Dec.	Oate 9,	Peters PA.	Town, State
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1,092	ite be executed iysician and ne burial-transit	ical Examiner	Sequentially list conditions, if any, leading, lo immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o him	a consequence of):		failure			Years Years
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	he Hospi in 24 hour he Funer pletely fill	Medicai	29a. Certifier (Check only one) Cartifying P	nysician: To the best minar: On the basis o and manner st	f examination and/or in	th occurred at the tim evestigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
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	The		30. Name and address of person who	completed cause of c	death (Item 23a) (Type,	Print)	Rock	alle r	December 5	r50
	Sta Registi		31. Date filed (Month, Day, Year)	004 32. Registr	ar's Signature	Spark	2			

State of Maryland / Department of Health and Mental Hygien [ ] [ ] Ls 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician 2*:15* BOYCE NDA LOV 1000 NOV 30 /Medical 4a. Fecility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner UNIVERSITY MARYLAND MEDICOL CENTER BALTIMURE Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth March 29,1967 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** Days Hours 1 □ M 2√ F Washington, DC 214-92-3029 37 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 X Yes 2 □ No Director Crofton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21114 USA 1672 Walleye Dr. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Prince Georges County Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental + Cora L. Thompson Charles R. Boyce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 i 246 Grey Fox Ct. Edgewater, MD 21037 Cora L. Boyce- Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. Ft. Lincoln Crematory 12/5/2004 Brentwood, MD \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BORTIC DISSECTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (ur as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 M Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 X No Completed 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A Inpatient 2 □ No 2 ER/Outpatient 3 DOA After thi Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pendina s after death. investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ro the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number SURGERY FELLOW AU 41 CARDIAC 30. Name and address of rerson who completed cause of death (Item 23a) (Type, Print) EBRIGHT, UNIV. OF MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 8 2004 Registrar

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Physician / Modical Examiner  Physic	2503 Carnaby Drive Baltimore, MD 21244 Place of Disposition (Name of Date 200 Location City of Town State)	Vonne M. Bishop (WiFe) 25 Method of Disposition 20b. Place of	Health ar tem 27 Is other trau
Physician / Modical Examiner  Physic	een Mount Crematory 12, 13-04 Baltimore, MD.	4 Donation 5 Other (Specify)	t. Pages rtment of rtant: If i
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	Exami		4a. Facility Name (If not institute Carroll Courses Social Security Number	1ty 6.5	eneral_	7. Age (In yrs.	last birthday) Yrs.	4b. City, Town Westmi If Under 1 Ye Months Da	nist ear   If U		8. Date of Bi	rth ay, Year)		place (State or Foreign
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Baltimore,	permit. Pages Department of Important: If i any injury or once.		1 ☐ Burial 2 ☑ Crema '4 ☐ Donation 5 ☐ Oth 21. Signatuse of Funeral	er (Speci	(v)	tate	view	. Name and Ad		1	0-2004	Balt	imore	
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	/Medio				A.	DUC	kler	own, or	Location of	of Death	11/25/		County of De	12:20	J A M
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	Funeral		5. Social Security Number 6 231-14-9116	Sex 1 □ M 2 <b>X</b> DXF	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Months	Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth	h 1 6%	9. B	irthplace (State Quintry) irginia	or Foreign
	Director		Usual Residence of Decedent								03/20/	1920	V	TIBTIITS	1
	arylan show	7	10a. State 10b. County			y, Town or Lo								10d. Inside (	•
	the M	Directo	Maryland Prince (	George's	For	estvi	10f. Zip 0	Code				10a Citiz	zen of What (		s 2x∏xNo
	h with	I Di	2805 West Avenue	Š			Tot. Zip c		20747			rog. Oitiz	US		
	r deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in U. prces?	S. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	1		nerican Indian,	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gir Year or D	ve		1 □ Yes X		Specify:		,		Specify:	Whit	e
2-00	72 hours after death with the Maryland "natural", or itams 23e or 28e-1 show of cal Examitrate, ust be rediffed at	ted	15. Decedent's (Specify only highest of	Education		16a. Dece	ient's Usual	Occupa	ation			16b. Kir	nd of Busines	s/Industry	
121		Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	kind of work DO NOT use		)	OF WORK	ng				
d 2	e filed within al Hygiene. I othar than '	e Co	12 17. Father's Name (First, Middle, La	st)		<u> </u>	Waitr	ess	18. Mothe	r's Name	(First, Middle,			ervice	
/lan	2 should be and Mental is marked o	To B	Phillip C. Via						Eliz	a Pe	arl Dou	glas	S		
Maryland 21215-0036	iges 1 and 2 should be filed it of Health and Mental Hyg it itam 27 is markad othal or othar traumetic avant,	13	19a. Informant's Name/Relationship			1					l Route Numbe				
ē,	Health tam 27 othar tra		David E. Buckler 20a. Method of Disposition	· / Son	20b. P	lace of Dispo	sition (Name	e of	-		tville.			20747 r Town, State	
Ö	Pages nent of nt: if i		1 🔀 Burial 2 □ Cremation 3  '4 □ Donation 🥕 □ Other (Spe			emetery, crer .ingtor				2/10	/2004	Arli	ngton.	Virgin	ia
Baltimore,	permit. Pages 1 Department of H Important: If ita any injury or ot	Arlington Cemetery 12/10/2004 Arlington Cemetery 21. Signatur Funeral Service Licensee 22. Name and Address of Facility P. Kalas Funeral Facility P.										al Hom	e PA	0745	
	7		23a. Pagl. Enter the disease, or co shock, or heart failure. List on	mplication; that of	aused the death									Approxima Interval Be	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	GESTIVE		EARLY	H	heup	E			Se	Onset and	
	Examiner			Due to	(or as a consequ	uence of):									
	₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to	(or as a consequ	uence of):									
	and and il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ	ience of):									
8760,	death certificate be executed e attending physician and id for use as the burial-transit			d	(0. 20 2 00.1004	31,00									
9	ntificat ng phy a as th	Physician/Medical	IF FEMALE:												
Вох	death certifica attending ph of for use as t	lan/l	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna pirth 2 Fetal	death 3	Ectopic preg					2:	3d. Date of de	. /	Year
o.	that the de ed by the detached	hysic	1 ☐ Yes 2∜ 130% 9 ☐ Unknown	9□ Unkn	ant at time of de	atin 5	Other (spec	спу)							
S, P	w requires that the s been signed by th should be detache	by P	Part II. Other significant conditions	contributing to d	eath but not resu	ulting in the ur	nderlying cau	use give	n in Part I.		23e. Did to	bacco us	e contribute	to the cause of	death?
ord	requir	eted						-			1 🗆 Y	es 2	(No 3□F	robably 4 🗌	Unknown
Vital Record	e la has	Completed									24a. Was a autops perfori	sy	24b. Were a prior to death?	utopsy findings completion of c	available cause of
ta	ician: Th certificate rector, pag	e	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes 5		1 🗆 Ye	s 2 No	
of V	dis d	To B	examiner? 1 ☐ Yes 🏋 🏋 No	- I de la composition della composition della co	The same to the sa	ER/Outpatien		-	r: 4XXNur		ne 5□Reside		□Other (Sp	ecify)	
	ding F h. After i funera	tlon:	27. Manner of Death		of Injury th, Day Year)	28b. Time of Injury	M 280	c. Injury Work	at ? ′es 2 □ N		8d. Describe ho	ow injury	occurred		
Division	or Attanding after death. Diractor: After in by the fune	ertification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury - At ho	me, farm, str				- 4	8f. Location (Si		Number or F	ural Route Nun	nber,
	ital or A	O		1	ng, etc. (Specify						City or Towi				
	To tha Hospital or Attanding Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Aedical	(Check only 2 Medical Ex	Physician: To the aminer: On the band man	best of my know asis of examinat ner stated.	wledge, death tion and/or inv	estigation, in	n my op	inion, deat	h occurre	ed at the time, d	ate and p	place, and du	e to the cause(s	s)
)	Wilt Con	W	29b. Signature and title of certifier	Mla	- 0	N	29c.	License	number	75	2			th, Day, Year) - 29, 2a	04
	7)		30. Name and address of person wh Wayne Allgaier,	//	e of death (Item 9th Av		,	c MD	. 217	16					
	Sta	. 4	31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ture .									
	Registr	ar	DEC 0 8 200	14 54	neva	B	Spar	6							

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of	Health ar f Death	nd Mental Hy	giene 00 L	38760
	Physici	an	Decedent's Name (First, Middle, L					2. Date of De	ath Day Ye	3. Time of Death
	/Medic	cal	George	David	Cool				er 30, 20	
	Examir	ier	4a. Facility Name (If not institution, g  Anne Arundel N		tor		or Location of	Death	4c. County of D	
	Funeval				e (In <i>yrs. l</i> as <i>t birthd</i> a)	Annap		Hrs. 8 Date of Birt	Anne Ar	
ì.	Funeral Director		115-14-5996 Usual Residence of Decedent	1\\\ M 2□F	79 Yrs.	Months Day		Min. 8. Date of Birt (Month, Da May 15	y, Year) , 1925 N	Birthplace (State or Foreign Country) ew York
	/land		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Man a-1 sh	tor	NY Westche	ster	Mt. Plea	sant				1 ☐ Yes 2 No
	th the or 28;	lred	10e. Street and Number			10f. Zip Code	1		10g. Citizen of What	Country?
	23a	al	381 Manhattan Av	enue, Hawt	horne	10532			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-1 show any injury or other treumatic event, I'm Medical Evair incrinial be troilled at once.	by Funeral Director	Narital Status     Never Married 2  Married     XWidowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 (X)Yes 2   N If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W Specify:	mencan Indian, hite, etc. White
Ö	2 hou	ed	15. Decedent's		16a. Dec	edent's Usual Occ	upation		16b. Kind of Busine	
215	hin 72 in "in	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4or 5	(Giv	kind of work don DO NOT use retir	e during most o red)	of working	TOO. INNIG OF DESINE	33 Houstry
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nd	al Hy al Hy a oth	Be (	17. Father's Name (First, Middle, Las	it)			18. Mother's	Name (First, Middle,	Maiden Sumame)	
yla	Ment Ment arked	2	Charles Coolen				1	y Griffen		
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relationship					or Rural Route Numbe		
e)	1 and Health Sm 27 ther t		Susan Koussouris  20a. Method of Disposition	Daughter	20b. Place of Disp		Thorn C	Court Mille		
Baltimore,	ages or of l		1 X Burial 2 ☐ Cremation 3		cemetery, cre	matory or other pl		Date	20c. Location - City	
≣	artme artme ortent injury		' 4 ☐ Donation 5 ☐ Other (Spec			Heaven C		2-4-04	Hawthorn	e, Ni
Ba	Depri Impo		V 1013 18/	200 last	()	Maher Fu	meral H		antrii 11 o	NY 10570
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	Pnysician /Medical	(	shock or heart failure. List only immediate Cause (Final disease or condition resulting in death)	. Cay	estrue	heae	+ fo	ulue		Interval Between Onset and Death
n	Examiner			Due to (or as	consequence of):		1			
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Ö,	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to (or as a	a consequence of):					
8760	cate be executed obysician and the burial-transit	dical		d						
9 ×	ding p	/Mec	IF FEMALE:	23c. If yes, outcome of	of programs.					
Вох	The law requires that the death certific te has been signed by the attending p page 2 should be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1☐Live birth :	2 Fetal death 3	Ectopic pregnant	су		23d. Date of d Month	lelivery Day Year
o.	w requires that the de been signed by the should be detached	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or death 3	Other (specify)				
ص	that ned by deta		Part II. Other significant conditions	contributing to death bu	it not resulting in the i	ınderlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Sp	quires n sign	ed by	Chronic C	Brucht	e Puli	uguceo	(1)ise	Cest 104	es 2 □ No 3 □	Probably 4-QUnknown
000	s bee	olete			,			24a. Was a	n 24b. Were	autopsy findings available
Vital Records,	: The taw cate has I page 2 s	Completed						autops perfori	med? prior to death	completion of cause of
<u>m</u>		0	25. Was case referred to medical				26. Place of	1 ☐ Yes  Death (Check only or	2 No 1 Y	es 2 No
	Physic this ce	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: Impatier	nt 2 ER/Outpatie	nt 3 DOA	than	ng Home 5 ☐ Reside		pecify)
ē O	ding Pl h. After th funera		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	f 28c. Inju		7*	ow injury occurred	
<u> </u>	r Attendi er death. rector: A by the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	ne			]Yes 2∏No			
Division of	of or Attend after death Director:	Certification;	4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Number or i n, State)	Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death as after death for the Funeral Birector: After this certification and the funeral director, and the funeral director director, and the funeral director director directors.		29a. Certifier 1 1 Certifying P	hysicien: To the best o	f my knowledge desi	h occurred that	ima data == 3	lane and due to the	auge(a)	a abasad
	e Hospitel 24 hours e Funeral letely filled	edical	(Check only 2 Medical Exe	miner: On the basis of and manner stat	examination and/or in	vestigation, in my	opinion, death	occurred at the time, d	ause(s) and manner attended and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	W)		29c. Licen	ise number	2	9d. Date signed (Mo	nth, Day, Year)
	2 1.1		Africa	Clera		DS	7028		11/30/11	L
1	510		30. Name and address of person who			Print)			1-100	1
	1		ADITYA CHOPRA,			Medica	l Parkwa	ay, Annapol	lis, MD 21	401
	Sta Registra		DEC 0 8 2004	32. Registra	r's Signature	rocks				

			1 - For State Registrar	Sta	te of Mar	ryland /		artmen <i>tificate</i>					giene Rag. Nd	711111	38761
	Physici		1. Decedent's Name (First, Middle RUSSE)_L		URCH	WAR	9					2. Date of De Month Decem	Da	ofty 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution					4b. City,	Town, or	Location	of Death	70-4	<u> </u>	. County of Death	
			Northwest Hosp	ital C	enter			Ra	nda1	.1sto	wn			Baltim	ore
	Funeral		5. Social Security Number	6. Sex 1⊠M 2	7. Age	(In yrs. last i		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	v, Year)	9. Birthp Cour	place (State or Foreign
	Director		388-26-2192 Usual Residence of Decedent			79	Yrs.					Dec. 2	8, 1	924 Wis	consin
	iand ow		10a. State 10b. County		1	10c. City, To	wn or Lo	cation						1	0d. Inside City Limits
	Mary	to	Maryland Balt	imore			0	wings	Mil	15					1 ☐ Yes 2 🛣 No
	n the	Director	10e. Street and Number					10f. Zip					10g. Cit	izen of What Cour	ntry?
	23e c	alD	7 Hawk Rise	Lane					211	17				U.S.A.	
	r dea	Funeral	11. Marital Status		is Decedent Ev ned Forces?	er in U.S.	13.	Was Deced	lent of Hi	spanic Ori n, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Americ Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If V	Yes 2 □ No es, Give			1 ☐ Yes 2	<b>№</b> No	Specify:				Specify:	hite
우	72 hours after death with the Maryland "netural", or Items 23e or 28e-f show clical Evantinet must be notified at	edk	15. Decedent		ar or Dates: W		a. Dece	dent's Usua	I Occupa	ation			16b. K	ind of Business/Inc	
215	nin 72 In "na	plet	(Specify only highes	t grade comp	nleted) llege (1-4or 5+)		(Give	kind of wor DO NOT us	k done d e retired	<i>luring</i> mos )	at of working	ng		tyof Wisc	•
21	filed within Hygiene. ther than "	Completed	Elomentally/Goodingary (G-12)		4		Sani	taria	an					alth Dept	
Maryland 21215-0036	d a b	Be	17. Father's Name (First, Middle,							18. Mothe	er's Name	(First, Middle	Maiden	Sumame)	
S		To	Everon		dward	Churc			/2:		Mar				tarch
Mai			19a. Informant's Name/Relationsl		•									or Town, State, Zip	
	is 1 and 2 of Health a item 27 ls other trei		Betty Louise Ch	irchwa	ra (wi	20b. Place	of Dispo	wk Ri sition (Nam	ne of			gs Mil. ate		MD 2111 ocation - City or To	
Baltimore,	0 0		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		I from State		-	n <i>atory or o</i> n Mem			12/15	/0/		1. <i>61</i> .13 T	74
Ħ	구두루		21. Signature of Funeral Service	•	0	WISC								stown Ro	Wisconsin ad
ä	Depar Depar Impo eny ir		Stephen	~ m	1 Jen	Kin	7	ELINE	FUN	ERAL	HOME	Reis	ters	town, MD	21136
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications	s that caused the	ne death. De	o not ent	er the mode	e of dyin	g, such as	cardiac or	r respiratory a	rrest,		Approximate Interval Between
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. META STATIC GAUSIANDER CASCINOMA  resulting in death)											4	Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as a										
М	_xummer	er	Sequentially list conditions	b	Due to (or as a	consequienc	n of):								
	ted nsit	nlne	Requentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		200 (0) 03 0	CONSCIQUENC	o 017.								
ď,	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	с	Due to (or as a	consequenc	e of):								
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical		d.											
9	ntifica ng ph as th	a)	IC CCAMALE.												
Вох	eath certific attending p for use as t	an/h	JF FEMALE: 23b. Was decedent pregnant in the past 12 months?		es, outcome of Live birth 2		th 3	Ectopic pro	egnancy					23d. Date of delive	,
0.	at the dea by the at tached fo	Physician/M	1 Yes 2 No		Pregnant at tir Unknown	me of death	5 🗆	Other (spe	ecify)					Month	Day Year
<u>α</u>	that the		Part II. Other significant condition	ns contributir	ng to death but	not resulting	in the u	nderlying ca	ause aive	n in Part I		23e. Did t	obacco i	use contribute to th	ne cause of death?
of Vital Records,	signe d be	d by	COLOMARY ART		DISEASI		23.1114	JU TES				1 🗆 '	Yes 2	□No 3□Prob	ably 4 ⊠Unknown
COL	w requir been s should	lete										24a. Was	an	24h Were auto	psy findings available
Re	e - e	Completed										autor perfo	osy rmed?	prior to con death?	npletion of cause of
ta	ien: Th rtificate tor, pag	Be C	25. Was case referred to medical							26. Place	e of Death	(Check only of	212KNo	1 ☐ Yes	2□ No
Ţ	ıysici is ce direc	To B	examiner? 1 ☐ Yes 2 █ <b>⊀</b> No	Hospita	l: MInpatient	2 🗆 ER/0	Dutpatier	t 3 DO	A Othe					6 ☐ Other (Specify	1)
0 0			27. Manner of Death 1 25 Natural 5 ☐ Pendin		Date of Injury (Month, Day 1	Year) 28b	Time of	2	8c. Injury Work	at ?	2	8d. Describe I	now injur	ry occurred	
sio	Attending or death. ector: After by the fune	catl	2 Accident investig	ation of be				М		/es 2□					
Division	I or Attend after death Director: ,	Certification:	4 Homicide determ		. Place of Injury building, etc.	y - At home, (Specify)	farm, str	eet, factory	, office		2	8f. Location (3 City or Tox		nd Number or Rura e)	l Route Number,
1	To the Hospital or At within 24 hours after o To the Funerel Direct completely filled in by		29a. Certifier 1 Certifyin	g Physician:	To the best of	my knowled	ge, death	) OCCUITED :	at the tim	e. date an	nd place a	nd due to the	cause/e	and manner as st	ated
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical one)	Examinar: O	the basis of e	xamination a	and/or in	vestigation,	in my or	pinion, dea	ith occurre	d at the time,	date and	d place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		A 4					number				te signed (Month,	Day, Year)
	1		1 Ranga	again	M.D			I	)54	1288	8		De	Cember (	sty 2004.
	5/1		30 Name and address of person Pamay Wamy T	who complete	ed cause of dea	ith (Item 23a	1) (Type,	Print) Vyest	++	ORIN	tal	Cente	·		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 08	2004	32. Registrar			Lo							

DHMH 17 Rev 1/2001

CUMMINS, JEANN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 15 per fh 8838 12-8-04 yt
State of Maryland PDepartment of Health and Mental Hygiene? 1 - For State Registrar 38762 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day\_5 **Physician** Cummins 1925PM Jeanne December 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HEALTHCARE AGNES BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☐ M 2 🕱 F 153-26-5342 73 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avent, the Medical Examiner must be notified at MD Baltimore DAK GWYNN Completed by Funeral Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō QUEENANNE STREET U.S. 4. 591212 21207 itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: if itam 27 is marked other than "ne any injury or other traumatic event, the Medie once. College (1-4or 5+) 4yrs. Elementary/Secondary (0-12) EDUCATION 17-th grade

17. Father's Name (First, Middle, Last) TEACHER/HOUSENIFE 18. Mother's Name (First, Middle, Maiden Surname) Be AUTHUR HARRIS HAZEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/57 591215 QUEENANNE STREET GNYNN DAK MO SHON CHAMINS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 112-10-04 ' 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON, VA ARLINGTON NATIL 21. Signature of Funeral Service Licen 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SRICE 5151 Baltimore Natil Pike Balto. MD 21229 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTHS Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Physician Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit attending physician and for use as the burial-trar Physician: The law requires that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 6 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificate has 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this s after death.
sai Diractor: After th 27. Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 738543 30. Name and address of per on whill completed cause of death (Item 23a) (Type, Print) Avenue Bultimore, Manyland 21229 900 KEUIN 11. cautitis ni Catin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 8 2004 Registrar

			1 - For State Registrar	State o	Maryland / De	partment of leartificate of			giene 3.2.004	38763					
	Physic	ian	Decedent's Name (First, Middle)	,				2. Date of Dea Month	ath Day Yea	3. Time of Death					
	/Med	ical	Melvin Leo Cag	e give street and num	nher)	4h City Town	or Location of Deat	12	5 200 4c. County of De						
	Exami	ner	4a. Facility Name (If not institution, 817 Camp Mead Hospice of the	e Rd.	ke		nthicum								
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth (Month, Day		Arundel  Birthplace (State or Foreign Country)					
	Director		213-16-5740 Usual Residence of Decedent	1 <b>∑</b> M 2□F	82 Yrs.	INOTHIS Days	TIODIS IVIIII.	Jan. 21		Maryland					
	/land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits					
	Mar.	to	MD An	ne Arunde	1	Linthic	11m			1 ☐ Yes 2 X No					
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?					
	s 23s	ra	513 Cheddington	·			090		United S						
215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, than "natural", or itams 23a or 28a-f show itam 27 is marked other than "natural", or itams 23a or 28a-f show othar traumatic event, the Medical Executaries as the natified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed For	2 X No e	i. Was Decedent of I If Yes, specify Cub		pecify Yes or No- o Rican, etc.)		merican Indian, hite, etc. White					
5-0	72 ho	eted	15. Decedent' (Specify only highest		16a. Dec	edent's Usual Occu	pation	king	16b. Kind of Busines	ss/Industry					
2	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1	life	DO NOT use retire	nd)	All 19							
d 21	filed v Hygie Ither t		8 17. Father's Name (First, Middle, L	ast)			18 Mother's Nan	ne (First Middle	Heidman Maiden Sumame)	Brewery					
Maryland	2 should be filed within and Mental Hygiene. ia marked other than aumatic event, the Ma	To Be	Thomas E. Cage	,					a Unknown						
ary	shou and M a mar	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	ling Address (Street			r, City or Town, State						
	and 2 ealth a n 27 is		Edith Cage Wife	2				Linthicu	ım, MD 210	90					
ore	Pages 1 nent of He int: If itan	1	20a. Method of Disposition  Burial 2X Cremation	3 □Removal from S	20b. Place of Dis cemetery, ci	position (Name of ematory or other pla	ce)	Date	20c. Location - City	or Town, State					
Baltimore,		1	*4 ☐ Donation 5 ☐ Other (Sp	ecify)	Bayview	Crematory	, Inc. 12	2-6-2004	Baltimor	e, MD					
Bal	permit. Departr Importa any inju	1	21. Signature of Ferrira Service L	Cenced					eral Home						
			23a. Part1. Enter the disease, or o	1328 Sulphur Spring Rd., Arbutus, MD 21227  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Interval Between											
	Physician		shock, or heart failure. List only one cause on each line.  Inmediate Cause (Final disease or condition resulting in death)  a												
8760,	The law requires that the death certificate be executed to the has been signed by the attending physician and to age 2 should be detached for use as the burial transit on	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that intitated events resulting in death) Last	c	or as a consequence of):					Ġ.					
.O. Box 6	that the death certifice led by the attending ph detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bi	int at time of death 5	□Ectopic pregnance □ Other (specify) □	у		23d. Date of d Month	elivery Day Year					
<u>α</u>	es that igned b	by Pf	Part II. Dther significant condition	s contributing to de	ath but not resulting in the	underlying cause giv	en in Part I.	23e. Did tot	bacco use contribute	to the cause of death?					
Records,	w require been sig should b							1 □ Y€	es 2 No 3 ∏ I	Probably 4 Unknown					
မင္ပင	e law re has be je 2 sho	Completed						24a. Was a		autopsy findings available completion of cause of					
E B		Соп						perform		)					
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ort 30 DOA Cth	105	th (Check only on							
of		. To	1 Yes 2 No  27. Manner of Death	1 In In 28a. Date o	patient 2 ER/Outpati	AIL SELDON	4 🗀 Nuising H		ence 6 Other (Sp ow injury occurred	pecify)					
Division	Attending F r death. actor: After by the funer	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga		i, <i>Day Year)</i> Inj <i>ur</i> y		rk? Yes 2 □ No								
<u>×</u>	or Attendation Diractor:	tific	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place	of Injury - At home, farm, s g, etc. (Specify)	treet, factory, office		28f. Location (St. City or Town	reet and Number or I	Rural Route Number,					
	To the Hospital or Attu within 24 hours after de To tha Funaral Diracto completely filled in by th														
	Hosp 24 hou Funa tely fil	edical	(Check only 2 Medical E	kaminer: On the ba	pest of my knowledge, dea sis of examination and/or	th occurred at the tir nvestigation, in my o	me, date and place, pinion, death occur	and due to the ca	ause(s) and manner a ate and place, and da	as stated. ue to the cause(s)					
	o the ithin 2 o tha	Mec	one) 29b. Signature and title of certifier	and mann	er stated.	29c. Licens	e number	25	9d. Date signed (Mor	oth. Dav. Year)					
	- 3 + ō		Mar	rang		D	29505	D	ecemb	21061					
	10		30. Name and address of person w	ho completed cause	of death (Item 23a) (Type	, Print)	<u> </u>		445	21261					
	*		4. Markan	205	Hospital	mive,	year 15	um e	, 1010.	21061					
	Sta Registi	-	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature										
DH	MH 17 Rev 1/2		DEC 0	3 2004	General	& Spor	w								
				/	ORIGIN	AL.	RS/								

			For State	State of Maryla		artment of H		_	200	20761		
			Registrar  1. Decedent's Name (First, Middle, Last	)		tineate of t	Dealli	2. Date of De.	Reg. N. UU	3. Time of Death		
	Physici				lvle			Month Decembe		ear M		
	/Medio Examir		4a. Facility Name (If not institution, give		1,16	4b. City, Town, or	r Location of De		er 5, 200 4c. County of 0			
			Carroll Hospital	Center		Westm	inster		Carro]	17		
	Funeral		5. Social Security Number 6. Se	x v 7. Age (In yi	s. last birthday)	If Under 1 Year Months Days	If Under 24 H	lin. 8. Date of Birl Sept. 4	th 9.	Birthplace (State or Foreign		
L	Director		237-30-3333	⊒м 2 <sup>4</sup> ⊑ғ 78	Yrs.			Sept. 4	7, 1926	NC NC		
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits		
	Maryl	jo	MD Carro	11	Syl	cesville				1 □ Yes 2 □ No		
	1 the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?		
	A with	0	1012 Waite Avenue			217	84		USA			
	deat	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?			ispanic Origin?	(Specify Yes or No	- 14. Race -	American Indian,		
9	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show I's Modical Exardiner", usi be notified at	/Fu	1 ☐ Never Married 2 🂢 Married	1 ☐ Yes <b>X</b> ☐ No If Yes, Give		1 ☐ Yes 2 💢 No	Specify:	eno nican, etc.)		White, etc.		
21215-0036	"natural", or	d by	3 Widowed 4 Divorced	Year or Dates:						White		
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of	working	16b. Kind of Busin	ess/Industry		
12	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	1110.	LPN	·/		Health C	·		
0	filled Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)			171 14	18. Mother's N	Name (First, Middle,		are		
lan	should be filed withir and Mental Hygiene. marked other than mattc event, the Mi	To B	Unknown	Butl	ler		L	enny Fe	aster			
Maryland	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene Item 27 is marked other than "natur other traumatic event, the Madical		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street	and Number or		er, City or Town, Sta	ite, Zip Code)		
	s 1 and 2 of Health of Item 27 i		Mr. Doyet W. Carly	le (Spouse)	1012	Waite Ave	enue Sy	kesville,	MD 21784			
ore	of He		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ F		. Place of Dispo cemetery, cres	sition (Name of matory or other place	re)	Date	20c. Location - Cit	y or Town, State		
Ë	Pag ment ant: I ury o		'4 □Donation 5 □ Other (Specify)		ew Oakla	nd Cemete	ery   12	/7/04	Sykesvi1	le, MD		
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o		21. Signature of Funeral Service Licens	HOME & CH	APEL, P.A 0)-795-14	. (Box 195)						
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the de	ath. Do not ent	er the mode of dyin	g, such as card	diac or respiratory ar	U ) = 793 = 14 rrest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	TO SEEDS ON SUCH MIS.	SEPS	15				Onset and Death		
	/Medical		resulting in death)	Due to (or as a cons	equence of):							
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687	phys the	edicai		d								
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of prec	nancy				23d. Date of	f delivery		
	death e atte	icia	in the past 12 months? 1 ☐ yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o		]Ectopic pregnancy ] Other (s <i>pecify)</i>			Month	Day Year		
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ec Sec	e law has b	npie						24a. Was	sv prior	e autopsy findings available to completion of cause of		
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Viital	9 6	o Be	25. Was case referred to medical examiner?	fospital:		• scape Othe	ar	Death (Check only o				
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on	ding th. : After s funer	tior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury							
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ā	F # F F	Cert	4   Hollidge	building, etc. (Spe	ciry)			City or Tow	m, State)			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Exemi	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or in	occurred at the time vestigation, in my op	ne, date and pla pinion, death o	ace, and due to the occurred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)		
	To th within To th	Me	29b. Signature and title of certifier	^		29c. License			29d. Date signed (M			
	ì		16. 1 A.	44611	1	130	JUL A	1-13	12/6/	04		
	V		30 Name and address of person who co	ompleted ause of death (It	em 23a) (Type,	Print)		1	, ,	40 21157		
	25.4		Syen S. M.	(Mh m')	447,	B Ma	in st	- Westh	uuster	MU 21107		
	Sta Registr		31. Dave filed (Month, Day Year) 200	32. Hegistrar's Sig	nature	Sparks	/					

			For State Ragistrar	State of Maryland /	Department of Health and M Certificate of Death	lental Hygier		38765
S	Physici	an	1. Decedent's Name (First, Middle, Last)	Cameron		2. Date of Death	Qay Year	3. Time of Death 2! ISA M
	/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		c. County of Death	D. (3.7)
			1525 Cantwel	IRa.	birthday) If Under 1 Year   If Under 24 Hrs.	0. Data of Birth	Baff	impre
	Funeral Director		5. Social Security Number 6. Sec. 129-28-1996	7. Age (In yrs. last)	Yrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea	434	ace (State or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location		1	Od. Inside City Limits
	a-f sho	ctor	Maryland Bat	imore	Wordlawn			1 No Yes 2 No
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at ances.	I Director	10e. Street and Number	Rd.	10f. Zip Code 21244	10g. (	Citizen of What Coun	123
	tems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Pueno	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	an Indian, etc.
036	al', or I	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ ⊀6 If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Bla	ck
21215-0036	n 72 ho "natur edical	leted	15. Decedent's Edu (Specify only highest grad	cation 16 ocompleted)	Decedent's Usual Occupation     (Give kind of work done during most of work)     iffe. DO NOT use retired.		Kind of Business/Ind	
212	giene. er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Factory Worker	C	an-Lov	very Glass
and	d be file intal Hy and oth	Be	17. Father's Name (First, Middle, Last)  George Booke		18. Mother's Name	(First, Middle, Maid	en Sumame)	V
Maryland	should and Mer s marke sumatic	₽	19a. Inform Name/Relationship (Ty	pe, Print) 1	9b. Mailing Address (Street and Number or Rura	al Route Number City	y or Town, State, Zip	Code) 21244
	1 and 2 Health a em 27 is		Enest Camero		of Disposition (Name of	Bath 20c.	Location City or To	withte
mor	Peges nent of l int: If its iry or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	come	etery, crematory or other place)  12	6/04 C	tonsvill.	e Manyland
Baltimore,	permit. Departm Importe any inju		21. Signature of Fundral Service Licens	Parker	22. Name and Address of Facility	Ker Fun	eral Sen	Want 2009
4			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Done cause on each line.	Do not enter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardio myo				Onset and Death  1 year
	Examiner		Sequentially list conditions,	Pulmonary	Hypertension			/
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)	ce of):			
oʻ	death certificate be executed e attending physician and of for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence	ce of):			
3876	physicist be street be	edicai		d				
Box 68760,	death certifica attending ph d for use as th	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delive	
P.O. E	the dea y the at ched fo	ysici	in the past 12 months? 1 ☐ Yes 2 SNo 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 ☐ Other (specify)		Morter	Day Year
	The law requires that the derate has been signed by the a page 2 should be detached for	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause given in Part I.		o use contribute to th	
Vital Records,	w requir been si should I	eted				1 ☐ Yes 24a. Was an		ably 4 Unknown  bsy findings available
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Vital	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	26. Place of Death	(Check only one)		
of	g Phys er this eral dir	n: To	27. Manner of Death	1   Inpatient 2   EH/	Outpatient 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how in	6 ☐Other (Specify jury occurred	)
Division of	Attending in death.  octor: After by the fune	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 Tes 2 No	29f Looption (Street	and Number or Rura	I Pouto Number
Divi	el or Al	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, larm, street, factory, office	City or Town, Sta		rioute Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely fitted in by the funeral director, page	edical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 11	29c. License number	29d. 0	Date signed (Month, I	Day, Year)
1	1		30. Name and address of person who co	ompleted cause of death (Item 23.	05/426	De	ecember	8,2004
1	21		Elliot Rothsch	1d, M.D. 400	00 old Court Rd	Pikesvi	He, Man	y land by
	Sta Registi		31. Date filed (Month, Day, Year)  NFC. 0 8 2004	32. Registrar's Signature	29c. License number 05/426  (a) (Type, Print) Court Rd  (b) Aparks		/ (	

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 12 - 03 - 2004 **Physician** JOHN Ν. CLASSEN 4:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTROSE AVENUE WOODBROOK BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-11-1916 9. Birthplace (State or Foreign **Funeral X**X M 2□ F Months 88 212-30-8533 Yrs Director MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahow tre Medical Examiner must be notified at 10d. Inside City Limits MD. BALTIMORE WOODBROOK Director 1 ☐ Yes 2(1)(No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6517 MONTROSE AVENUE 21212 U. S. A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after XXYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: WHITE ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MEDICAL DOCTOR filed within I Hygiene. College (1-4or 5+) PLUS Elementary/Secondary (0-12) BALTIMORE SUN PAPER 5 PHYSICAN permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If Item 27 is marked other 1 any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HENRY WASHINGTON CLASSEN MARY WARD RAYNER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SPOUSE) MARGARET S. CLASSEN 6517 MONTROSE AVENUE, BALTIMORE, MARYLAND, 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial Cremation 3 Removal from State
4 Donation 5 Other (Specify) HILLTOP SERVICE CORP. 12-04-2004 TOWSON, MD. 21204 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD N.A.K RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) proviscolar Physician /Medical Examiner 1 fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 21X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death Check onl one examiner? Cther: 2 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ★ esidence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director; 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical pletely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 10 29d Date signed (Month, Day, Year) Tellell Ugleray 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6301 N.CHHILES ST BALTIMORES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks DEC 0 8 2004 Registrar

			For State Registrar	State o	f Marylan		artment of H		d Mental H	ygiene Reg. Nea		
	Physici		1. Decedent's Name (First, Middle	rice (	lrew				2. Date of Month		004 6204	3 100 of 160 th / 5:15 A M
	/Medic Examir		4a. Facility Name (If not institution Baltimore Rehabilit	give street and nur	VA	are Cent	4b. City, Town, or er Baltimo				County of Death	
	Funeral Director		5. Social Security Number 216-09-6924 Usual Residence of Decedent	6. Sex 1 M M 2 ☐ F	7. Age (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of 1 (Month, 101–18–1	Birth Day, Year) 1907	9. Birth Cou Virg	
	Maryland f show	tor	10a. State 10b. County MD NA		10c. City	, Town or Lo						10d. Inside City Limits
	3e or 28e	Il Director	10e. Street and Number 1701 N. Eutaw Stre	eet Apt. 920	)		10f. Zip Code 21217			10g. Citiz	en of What Cou USA	ntry?
920	d within 72 hours after death with the Maryland Jiene. r then "netural", or Items 23e or 28e-f show the Medical Evantre must be traffiled at	by Funeral	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dece Armed Fo	edent Ever in U. rces? 2 🗆 No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin n, Mexican, P Specify:	? (Specify Yes or l uerto Rican, etc.)		4. Race - Ameri Black, White, Specify: Blact	etc.
Maryland 21215-0036	within ne. then "	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1	-4or 5+)	(Give life. l	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of	working	16b. Kin	d of Business/In	dustry
land 2	be filed ntal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, I Elijah Crew	Last)		iruc	ck Driver		Name (First, Midd Eddie		nber Compa Gumame)	ту
	nd 2 shalth and 27 is in treum		19a. Informant's Name/Relationsh Irene G. Crew/ W	, , , , ,		1701	ng Address <i>(Street a</i>		920 Baltin			Code)
Baltimore,	permit. Pages 1 a Department of Hes Importent: If Item any injury or othe once.		20a. Method of Disposition 1	necify)	State	emetery, cren ison For	sition <i>(Name of</i> natory or other place cest Veteran	Cemi. 1	Date 2-09-04		ation - City or T	
Bal	permil Depar Impor any in		21. Signature of Funeral Service-	m		W		L Home 6			t Baltimor	re, MD 21217
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Dev	aused the deatr ach line. Yent or as a consequ	ia, A			type			Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any least immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	or as a consequ							
.O. Box 6	the death certifi y the attending I iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live b	come of pregna irth 2 □ Fetal ant at time of de own	death 3□	Ectopic pregnancy Other (specify)			23	3d. Date of deliver	ery Day Year
rds, P	sigr d be	by	Part II. Other significant conditio	ns contributing to de	eath but not resu	ulting in the ur	nderlying cause give	n in Part I.			e contribute to t No 3 ☐ Prot	ne cause of death? ably 4 dbmknown
al Records,		Completed							24a. We aut per 1 🗆 Yes	opsy formed?	prior to co death?	psy findings available mpletion of cause of
of Vital	Physicien: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No			ER/Outpatien		r: 4 Nursir	Death <i>Check onl</i> ng Home 5 ☐ Re	sidence 6		v)
Division o	ding h. After funei	Certification:	27. Manner of Death  1 PNatural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation	of Injury h, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 □ No	28d. Describe	how injury	occurred	
Divi	in the		4 Homicide determi	ned 289. Place buildir	ng, etc. (Specify	·) 	eet, factory, office		City or T	own, State)		l Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one)  2 Medical 8	g Physician: To the examiner: On the ba and mann	asis of examinat	wledge, death ion and/or inv	occurred at the tim restigation, in my op	inion, death o	lace, and due to the courred at the time	, date and p	lace, and due to	the cause(s)
)	Z \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Peng C	m	m				48		signed (Month,	
8	7/9		30. Name and address of person very L Co	IVIN	e of death (Item  O  egistrar's Signat	23a) (Type, 10 No	DOO orth Gr	eene	Street	- Bo	ultini	ire
	Sta Registr	te ar	31. Date filed (Month, Day, Year) DEC 0 8 20	04 30	egistrar's Signal	la ,	Sports					

			1 - State of Maryland / Deports State of Maryland / Deports State of Maryland / Ce	artment of Health and M	ental Hygier	ne2004 38768
	Physici /Medic		Decedent's Name (First, Middle, Last)  Elwood Orville Cooper		2. Date of Death Month	Day Year 3. Time of Death 22 2004 7:20 PM M
	Examin		4a. Facility Name (If not institution, give street and number)  Stella Maris Hospice	4b. City, Town, or Location of Death  Towson		4c. County of Death  Baltimore
	Funeral Director		5. Social Security Number 212-07-2720  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye. 05/21/191	
	ne Maryland 8e-f show olilied st	Director	10a. State         10b. County         10c. City, Town or Low           MD         Harford         Forest F	Hill		10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel" or items 23e or 28e-1 show importent; If item 27 is marked other than "naturel" or items 23e or 28e-1 show appropriately or other treumatic event, the Madical Examinar must be notified at ance.	Funeral Dire	10e. Street and Number  2018 Phillips Mill Road  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Armed Forces?	10f. Zip Code 21050  Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	τ	Citizen of What Country?  J. S. A.  14. Race - American Indian, Black, White, etc.
5-0036	72 hours aft 'naturel', or i	by	15. Decedent's Education (Specify only highest grade completed)	1 ☐ Yes 2 ☑ No Specify:  dent's Usual Occupation skind of work done during most of working	16b	Specify: White  Kind of Business/Industry
1212 pt	e filed within Il Hygiene. other than '	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)  TVICE Person  18. Mother's Name	(First, Middle, Maid	B, G, & E en Sumame)
Baltimore, Maryland 21215-0036	d 2 should be th and Mental 7 is marked c treumatic eve	ToE		ng Address (Street and Number or Rural		y or Town, State, Zip Code)
more,	Pages 1 and nent of Health snt: If Item 27 ury or other t		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, cre.	78 Stirling Drive - Distion (Name of malory or other place)  Mem. Gardens 12/06	ate 20c.	Location - City or Town, State
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee	2. Name and Address of Facility E. 1750 Belair Road -	F. Lassah Kingsvil	n Funeral Home, P.A. le, Maryland 21087
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE HEART Due to (or as a consequence of):			Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			
O. Box 687	The law requires that the death certificate attending physiste has been signed by the attending physicage 2 should be detached for use as the	by Physician/Medicai		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 🙀 Unknown
al Record		Completed			24a. Was an autopsy performed'	
Division of Vital	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner?  1	f 28c. Injury at Work?  M 1   Yes 2   No	ne 5 □ Resid <i>e</i> nce 8d. Describ <i>e</i> how in	6 Other (Specify) HOSPICE.
2	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b		4 Homicide  determined  200. Place of injury Actionine, farm, still building, etc. (Specify)  29a. Certifier (Check only)  (Check only)  Medical Exeminer: On the basis of examination and/or in	h occurred at the time, date and place, a	City or Town, St	(s) and manner as stated.
V	To the H within 24 To the Fi	Medicai	one) and manner stated.  29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	154		30. Name and address of person who completed cause of death (Item 23a) (Type,	· · · · · · · · · · · · · · · · · · ·	MD 015-7	12/3/04
	Sta Registi		31. Date filed (Months Dev. Year) #32. Registrar's Signature	LEY RD. TIMONIUM,	MD 21093	

DECEMBER 2, 2004 7:20 p.m.

ELWOOD COOPER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) -Day 2004 November **Physician** Wayne Douglas Crouse 9:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 951 9. Birthplace (State or Foreign Country) Mary land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 X M 2 ☐ F 53 217-76-1400 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 X Yes 2 No MD Carroll Director Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 299 W. Main St. U.S.A. or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 \ No Specify: Specify: Š 3 Widowed 4 Divorced White netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be .. Pages 1 and 2 should be f tment of Health and Mental P tent; if item 27 ie markad of G. Paul Crouse Helen Carrie Lambert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health at: If item 27 is Thelma C. Reaver - sister 2791 Miles Ct., New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 12/1/2004 Sykesville, MD \* 4 ☐ Donation — 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature/of/Funeral Service Licensee Depart Import any in 310 Church St., New Windsor, MD 21776 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due ti (or as a consequence of): Physician Preumere /Medical Examiner Sequentially list conditions, Sequentially list condition to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown

Division of Vital Records, P.O. Box 68760

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Doucets

The law requires that the death certificate be executed Completed 24a. Was an autopsy performed 2 0 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) | Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA this ieral Director; After th 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifier

State

ompleted cause of death (Item 30. Name and address of person who oe. Print)

eische 31. Date filed (Month, Day, Year) 32. Registrar's Sig

DEC 08 2004

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Registrar

SUMMER MICHELLE 04-7580	THOMPSON CASTLEMAN Please Type or Print Amend / Unpend iteml State of Mar  1 - For Amend Item 28f per me C Registrar  1. Decedent's Name (First, Middle, Last) Summor Mid	t in Black Indelible Ink. Ensure A 23a 27, 28a-f, perME, C838, I Viand 7, 28a-f, perME of Health and N	II. Copies Are Legible.
	Registrar  1. Decedent's Name (First, Middle, Last) Symmer Michael CASTLEM  SUMMER MICHELLE CASTLEM	chelle Thompson Castleman	
Physician /Medical			NOVEMBER 25, 2004 10:24a M
Examiner	4a. Facility Name (If not institution, give street and number)  224 NORTH CLEVELAND AVENUE	4b. City, Town, or Location of Death HAGERSTOWN	4c. County of Death WASHINGTON
Funeral Director	234-19-2767 1DM 21 F	(In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 24 Yrs. Months Days Hours Min.	8. Date of Birth (Month Pay Sear) 9. Birthplace (State or Foreign O9/20/1980
Maryland e-f show lifed at	Usual Residence of Decedent  10a. State 10b. County  MD MONTGOMERY	10c. City, Town or Location ROCKVILLE	10d. Inside City Limits 1  Yes 2 No
6 after death with the Marylan or items 23a or 28a-f show niner must be motified at Funeral Director	10e. Street and Number 304 CROYDON AV.	101. Zip Code 20850	10g. Citizen of What Country?
036 ours after deal art, or items; Examinat mu by Funer:	11. Marital Status  1 Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E. Amped Forces?  1 Mys 2 Not Status  14. Was Decedent E. Amped Forces?  1 Mys 2 Not Status  15. Was Decedent E. Amped Forces?  1 Mys 3 Not Status  16. Was Decedent E. Amped Forces?  1 Mys 3 Not Status  17. Was Decedent E. Amped Forces?  1 Mys 3 Not Status  18. Was Decedent E. Amped Forces?  1 Mys 3 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 3 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 3 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 4 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 5 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 5 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 5 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 5 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 6 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 7 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 7 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 7 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 7 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 7 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 8 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 8 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 8 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 8 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 9 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 10 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 10 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 10 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 10 Not Status  19. Was Decedent E. Amped Forces?  1 Mys 10 Not Status  10 Not S	If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: WHITE
Baltimore, Maryland 21215-0036  Department of Health and Mental Hygiene. Department of Health and Mental Hygiene, natural; or Itams 23a or 28a-f show morten: If Itams 27 is marked other than "natural; or Itams 23a or 28a-f show my injury or other treumatic event. I'm Medical Examinar must be notified at once.  To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  STUDENT	16b. Kind of Business/Industry  EDUCATION
yland 2 uld be filed the filed the filed other aric event. It	17. Father's Name (First, Middle, Last) GARY WAYNE CASTLEMAN		e (First, Middle, Maiden Sumame) ore VanMiddlesworth
Baltimore, Maryland permit. Pagas 1 and 2 should be fit. Department of Health and Mental H Importent: If tiem 27 1s marked oth eny injury or other treumatic even one.	19a. Informant's Name/Relationship (Type, Print) Honore VanMiddle (Type, Print)	THER 816 MULBERRY DR., MA	- 1.1. H.S.V.
Pages 1 Pages 1 ment of H lent: If itel	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) SMITHSBURG CREMATORY	unk 20c. Location - City or Town, State SMITHSBURG, MD
Balt permit Depart Import ence.	21. Signature of Funeral Service Licensee Charles M. Broe		DWN FUNERAL HOME, P.O. BOX 821, ., MARTINSBURG WV 25402
Pnysician /Medical Examiner	Due to (or as a	ne death. Do not enter the mode of dying, such as cardiac.  Intoxication consequence of):	or respiratory arrest, Approximate Interval Between Onset and Death
ecuted and transit arminer	cause. Enter Underlying Cause Classas or injury that initiated events c.	consequence of):	
Box 68760, eath certificate be executed attending physicien and for use as the burial-transit clan/Medical Examir	Due to (or as a	consequence of);	
Records, P.O. Box 68760, The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit completed by Physiclan/Medical Examir	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tire 9 Unknown	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
cords, P.O.  requires that the depensioned by the detached by Physic	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nonown
	25. Was case referred to medical		24a. Was an autopsy performed?  152 Yes 2 \( \) No \( \) Were autopsy findings available prior to completion of cause of death?  1 2 Yes 2 \( \) No
n of 'n of wing Physing Physical discurrent	examiner?  1 X Yes 2 No Hospital: 1 Inpatient  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1 As Date of Injury  1 Accident	28b. Time of 28c. Injury at Work?	me 5 ☐ Residence 6 X Other (Specify)SCENE  28d. Describe how injury occurred Unk.
_ \$ 5 \$ \$ \$ \$ O	Scene	y - At home, farm, street, factory, office (Specify)	28f. Location (Street and Number or Rural Route Number, Hacerstown 224 Cleveland Ave
the Hosp thin 24 hour thin 24 hour the Funel mpletely fil	29a. Certifier 1 ☐ Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of e and manner state  29b. Signature and title of certifier	my knowledge, death occurred at the time, date and place, xamination and/or investigation, in my opinion, death occurred.  29c. License number	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
wir roo	· auct	OCME	29d. Date signed (Month, Day, Year) NOVEMBER 26, 2004
CALL	30. Name and address of person who completed cause of dea RUNS 10, M 31. Date filed (Month, Day, Year) 32 Registrar	D 111 PENN STREET, BAI	TIMORE, MARYLAND 21201
State Registrar	DEC 0 8 2004	s Signature	

Paige Simon Davis amend 10,19 per F.H. Die amend 1 per Dr. g842 4/14/05 KBH 04-07769 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RPD State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene Control of Health And Mental Hygiene Control of 2. Date of Death 1. Decedent's Name (First, Middle, Last) Paige Simon Davis Simone Marie Davis parge Simone Marie Davis December **Physician** 2004 0219 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Community Hospital Prince George's Lanham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 26, 20 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min. 1□M 2√FF N/A 2004 Washington, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral', or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 ☐ No Completed by Funeral Director MD Prince George's

10e. Street and Number Carrollton New Carollton 10f. Zip Code 10g. Citizen of What Country? 8400 Caroliton Parkway 20784 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Mudical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be t 2 Shon S. Coates Caprice N. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carrollton Carrollton 19a. Informant's Name/Relationship (Type, Print) Health 400 Caroliton Parkway New-Garoliton, No. 20784
ace of Disposition (Name of Date 20c. Location - City or Town, State Caprice N. Davis/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit, Pages i Department of H Importent: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery | 12/9/2004 Brentwood, MD 21. Signature of Funeral Trvice Ucensee Fort Lincoln Funeral Home 3401 Bladensburg Rd. 1/rom Brentwood, MD 20722 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sudden Unexplained Death in Infancy(SUDI) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as the esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 2 No Month Day Year 5 Other (specify) 4□Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? 2 No 1 X Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1X Yes 2 □ No Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury Found: Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred unk Certification: Found: 5 Pending investigation 1 Natural  $\mathbf{a}^{\mathsf{M}}$ 1 ☐ Yes 2 No hours after death, 2 Accident Director: 12-3-04 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8400 Carrollton Pkwy New Carrollton, Maryland 4 - Homicide Found at residence within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ZAPI4CLI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 8 2004 Registra

			1 - For State Registrer		ryland / Dep		Health and I	Mental Hygi	g. No. 2001	÷ 38772
	Physici /Medic		Decedent's Name (First, Middle, Last,     Arlene	Dixon E	1ste			2. Date of Death Month Decembe	r 6, 2004	3. Time of Death 3:15pm M
	Examir Funeral		4a. Facility Name (If not institution, give Ruxton Manor Care 5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday,	Pikes		8. Date of Birth	4c. County of Dea	
	Director		218-32-5102	м X 6	9 Yrs. 10c. City, Town or L		Hours Mill.	Feb. 10,	1935	10d. Inside City Limits
	h the Marylan or 28a-f show a notitied at	Irector	MD Baltime	ore	Baltim	ore 10f. Zip Code		10	g. Citizen of What C	1 ☐ Yes 2 📉 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinating the notified at ances.	by Funeral Director	7 Sudbrook Lane  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ender Armed Forces?  1  Yes 2  No If Yes, Give	ver in U.S. 13.	212 Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 🖫 No	Hispanic Origin? (S pan, Mexican, Puerto	Decify Yes or No- Decify Yes or No- Decify Yes or No-	USA  14. Race - Am Black, Whi	
21215-0036	within 72 hour ene. than "natural' ne wedfeal Ex	Completed b	3 XWidowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)  12	Year or Dates: lication e completed) College (1-4or 5+	(Give	edent's Usual Occu e kind of work done DO NOT use retire	during most of wor ed)	king	6b. Kind of Business Health C	
Maryland 2	should be filed with nd Mental Hygiene. s markad other than umatic evant, the	To Be Co	17. Father's Name (First, Middle, Last) Charles Dixon				18. Mother's Nam	ne (First, Middle, M Ina Day	aiden Sumame)	
	1 and 2 sho Health and sm 27 Is ma		19a. Informant's Name/Relationship (T) Ms. Jessica Wisne: 20a. Method of Disposition		r) 2044	8 Aspenwo	ood Lane,	Montgome	City or Town, State, ry Village Oc. Location - City or	e,MD 20886
Baltimore,	Department of Pages Department of Papartment: If its mportant: If its any injury or of		1  Burial 2  Cremation 3  F  '4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licens			ew Mem. 1	Park   12/8	3/04 S	ykesville	, MD
E B	Depa Impo any ic		Buan 2.  23a. Part 1. Enter the disease, or complete	Dice that caused to	he death. Do not en				EL (Box 19 -795-1400 st.	Approximate
	Fnysician /Medical Examiner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	_	OSHC6 My consequence of)	elins				Interval Between Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause Clegace or injury	Due to (or as a	consequence of):					
O. Box 68	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	cy		23d. Date of de Month	elivery Day Year
ecords, P.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions co.	ntributing to death but	not resulting in the t	underlying cause g	ven in Part I.			o the cause of death?
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ion of Vital	Attanding Physician: Thr death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medicat examiner?  1  Yes 2 No  27. Manner of Death  1  Actural 5 Pending investigation	Hospital: 1 ☐ Inpatien 28a. Date of Injury (Month, Day		of 28c. Inju	her: 42 Nursing H	th (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spe	ecify)
DIVISION		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	examination and/or in	nvestigation, in my	opinion, death occur	red at the time, dat	e and place, and due	e to the cause(s)
	To t To t	Z	29b. Signature and title of certifier	Mille M	D		47683		d. Date signed (Mont	th, Day, Year)
	9		30. Name and address of person who co		ath (Item 23a) (Type, cut Sinte:		ushown M	D 21136		
	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 8 2004	32. Registrar	's Signature	parks				

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	hysici /Medic xamir	al	Decedent's Name (First,     Maurice M.      Aa. Facility Name (If not ins.)	Fe	erguson	ber)				Location o		2. Date of Dea Month DEC.	3, 20	Year )04 unty of Death	3. Time to	
	ineral		PRINCE GEO  5. Social Security Number	RGES	HOSPITAL	. Age (In yrs.	. last birthday,	CHE	EVERI		24 Hrs.	8. Date of Birtl	PF	9. Birth	GEORGE	or Foreign
D	ector		174-70-3786 Usual Residence of Deceder 10a. State 10b. C	nt	ILIAN ZUF	21	Yrs.				M	lay 24,	1983	Pen	nśylva 10d. Inside C	nia
the Maryl	28a-f sho	rector	PA Bu	cks		Wa	rwick	10f. Zip	Code				10a. Citizen	of What Cou	1∭ Yes	2 No
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within 72 hours after death with the Maryland ene.	27 is marked other than "neturet", or items 23e or 28e-1 show treumetic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 X Never Married 2 □ 3 □ Widowed 4 □ Div	Married	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? ∑∑No	J.S. 13.	Was Deced If Yes, spec		ispanic Ori n, Mexican Specify:	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	14. [	Race - Ameri Black, White		
od within 72 hours aff	han 'netur	Completed	15. De (Specify only Elementary/Secondary (C		ducation ade completed)	4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired	ation during most )	t of working	g		f Business/Ir	ndustry	
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2 should and Men	s mar umat	-	19a. Informant's Name/Rei	ationship (	Type, Print)		19b. Maili	ng Address	(Street a			Route Numbe			p Code)	
⊂ ≂ '			Mark Fergus	on (I	Father)	no.	_			CONTRACTOR TO SERVICE		rwick,				
Pagas ent of	Importent; if item eny injury or othe once.	o Marchael America	20a. Method of Disposition  1 X Burial 2 ☐ Crem  4 ☐ Donation 5 ☐ Ot	er (Speci	(y)	late	Place of Dispo cemetery, cre vlestov	vn Cen	neter	cv	Da	1/04	Doyle Bucks	Count	own, State Borous	gh,
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	sician and burial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	{	c	r as a consec										
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	ate has page 2	Completed										24a. Was a autops perform	sy	prior to/co	opsy findings empletion of c	available ause of
3	this certific al director,	To Be	25. Was case referred to mexaminer? 1 X Yes 2 □ No	edical	Hospital: 1 □ In		EP/Outpatier	nt 3 🗆 DO	Othe	. Fr		<i>Check only or</i> e 5 ☐ Reside		Other (Specia	fy)	
	Arter	tlon:		ending ivestigatio	28a. Date of (Month)		28b. Time o Injury	- M	8c. Injury Work		. P	d. Describe h	7			
I or Attending after death.	Director:	Certification:	3 Suicide 6 X 0	ould not be etermined	12 3	f Injury - At h	1:05 lome, farm, str	A		Yes 2 🛣 N	28	truck f of Location (Sincity or Town wdoin a	reet and Nu	mber or Rura		
the Hospital hin 24 hours	onne Funerel Directo completely filled in by th	edical C	29a. Certifier 1 Ce (Check only 2 Me	rtifying Pl dicel Exa	nysician: To the b miner: On the bas and manne	est of my knows	owledge, deat	h occurred avestigation,	at the tim , in my op	e, date and pinion, deat	d place, an	d due to the c	ause(s) and	manner as s	tated	
To the	compl	Med	29b. Signature and title of c	ertifier	Dre (10	all	Mn	29c	O.C	number C.M.E		2		ned (Month, 4, 20		
			30. Name and address of p	erson who	1. KO	RISU	111 PEN	N STR	REET,	BALT	rimor:	E, MARY				
F	Sta Registr		31. Date filed (Month, Day, DE		2004 32. Rec	ntrar's Sign		Cont	رع							

			1 - For State Registrar		State of	Marylan	•	artment of F tificate of		Mental Hyg	jiene 1000	38774	
	Physici /Medic		Decedent's Name (Firs     Howard Will		orbes					2. Date of Dea Month 11/1	th Day Ye	3. Time of Death 7:45am M	
	Examin		4a. Facility Name (If not in	nstitution, give	street and numb	oer)		4b. City, Town, o	r Location of Dea	ith	4c. County of [	Death	
			Gilchrist Ce			Age (In use	la ad trimbula . N	Tows	on If Under 24 Hr	s   0 0 (D:u)		ltimore	
	Funeral Director		5. Social Security Number 218–36–9929	1 [	x 2□ F	Age (In yrs.	Yrs.	Months Days	Hours Mir	. (Month, Day	/1939 <sup>9.</sup>	Birthplace (State or Foreign Country) Maryland	
	land		Usual Residence of Dece 10a. State 10b.	County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	_
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	3a or 28	il Director	10e. Street and Number 42 A Cak	Grove Dr	rive			10f. Zip Code	21220	1	log. Citizen of Wha	t Country?	
036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or Itams 23a or 28a-f show avent, the Medical Evanting runst be redified at	by Funerai	11. Marital Status  1 Never Married 2	Married Divorced	12. Was Deced Armed Forc 1 Tyes 2 If Yes, Give Year or Date	es? Aı □No Aı	rmy I	Nas Decedent of H f Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, Vhite, etc. White	_
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Maryland	and and ls m	Ĭ.	19a. Informant's Name/R Mary F. Forb							Rural Route Number		e, Zip Code)	
Baltimore,	m 0 .		20a. Method of Dispositio  1 → Burial 2 □ Cree  1 4 □ Donation 5 □ 0	mation 3 🗆 F		ate c	emetery, cren	sition (Name of natory or other place Cemetery		Date 23, 2004	20c. Location - City		
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral			P. Doda,	Jr. 22	. Name and Addre	ss of Facility	eral Home, Baltimore			
			23a. Part1. Enter the disc shock, or heart failu	ease, or comp	lications that cau	ised the death	h. Do not ente	er the mode of dyir	ng, such as cardia	ac or respiratory arr	est,	Approximate Interval Between	
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ı	Examiner	-	Sequentially list condition if any, leading to immedia	ns,	b	as a consequ							
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ate ⊀	io) of end	as a consequ	uerice or):						
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.O. Box	law requires that the death certi as been signed by the attending 2 should be detached for use a	Physician/M	23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nant	1 Live birt	h 2 ☐ Fetal nt at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	-		23d. Date of Month	delivery Day Year	
٥	juires that n signed b ild be deta	by	Part II. Other significant	conditions co	ntributing to dea	th but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tol	11	e to the cause of death?  Probably 4 Unknown	
Vital Records,	e law requir has been si je 2 should l	ompieted								24a. Was a autops	v prior	autopsy findings available to completion of cause of	
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1 of		-	27. Manner of Death		28a. Date of		28b. Time of	28c. Injur		Home 5 Reside	once 6 Other (5 ow injury occurred	specify (TOSPIC	-
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Division	a Hospital or Attend 24 hours after deatl a Funaral Diractor: etely filled in by the	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place o building	f Injury - At ho , etc. <i>(Specif</i> )	ome, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number of 1, State)	Rural Route Number,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical (	29a. Certifier (Check only 20 N	Certifying Phy Medical Exami	sician: To the b iner: On the bas and manne	is of examina	tion and/or inv	estigation, in my o	pinion, death occ	e, and due to the caurred at the time, d	ate and place, and a	fue to the cause(s)	
) ,	To the within 2 To tha complet	W	29b. Signature and title of	tertifier the	in h	On.	uno	29c. Licens	e number	2	9d. Date signed (M	onth, Day, Year)	
5	A CONTRACTOR OF THE PARTY OF TH		30. Name and address of	person who or	ompleted cause	of death (Item	6 70	Print) N. C.	hode .	St Reel	to Md	2,204	
	Sta Registr		31. Date filed (Month, Da)	y, Year)		istrar's Signa	iture	Spar	KN			onth, Day, Year)  Per 19, 2004  20204	

Torbes, Howard 11119/64

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM **THOMAS** FELTS, 5:17 P. M 04 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARTLEY HALL NURSING HOME POCOMOKE CITY WORCESTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XX M 2□ F 215-07-9954 94 VÍRGINIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits ir then "naturel", or items 23e or 28e-f shoving Medical Examiner outst be notified at MD. SOMERSET MARION STATION 1 ☐ Yes 2 X X lo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28143 CHRISFIELD MARION ROAD 21838 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Yes 2**X**X\0 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 δ 1 ☐ Yes 2/XNo Specify WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Madie once. Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) LUMBER FORMAN YARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN CONWELL **FELTS** LAURA HINES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21838 MILDRED V. FELTS (WIFE) 28143 CHRISFIELD MARION RD., MARION STATION, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY M.G. 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 12-8-2004 TIMONIUM, MD. 21093 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON,MD.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 □Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been sign 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No Division of Vital 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific gompletely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1006-Nou 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 8 2004

			1 - State Registrar	State of M	Maryland /		artment of H		nd Mental Hy	giene	200	4 38776
	Physici /Medic		1. Decedent's Name (First, Middle, Las Frank Fraction	st)				•	2. Date of D Month	eath Day	y Yea	A. LAL 'S D M
}	Examir		4a. Facility Name (If not institution, give St. Agues  5. Social Security Number 6. S	Healt			4b. City, Town, or Batti u		Death D	40.	. County of De	
Į,	Funeral Director			X M 2□F	68	Yrs.	Months Days	Hours	4 Hrs. 8. Date of Bi Min. (Month, D 02-11-19	ау, <i>Year)</i> 936	Mary	Country) 7 land
	e Maryland ta-f show	ctor	10a. State 10b. County MD NA		10c. City, To		timore					10d. Inside City Limits 1 TYYes 2 □ No
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936	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or Items 23e or 28e-f show event. the Medical Exarting retination and death.	by Funeral	601 Denison Street  11. Marital Status  1 □ Never Married  2 Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 V Yes 2 [ If Yes, Give Year or Dates	s? ⊡ No		If Yes, specify Cuba	spanic Origi n, Mexican, Specity:	in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ar Black, Wi Specify:	USA merican Indian, hite, etc. Black
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Mar	and and last in the second		19a. Informant's Name/Relationship (Sarah L. Fraction/ Wife		,				or Rural Route Numb imore, MD 21		or Town, State	, Zip Code)
Baltimore,			20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specifi	Removal from Sta	20b. Place ceme	e of Dispo etery, crei	sition (Name of matory or other place rest Cemete:	9)	Date 2-10-04	20c. Lo	gs Mills	or Town, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	1500	t	22	. Name and Addres	s of Facility	38 N. Gilmor	C+	Do 1 timow	MD 21217
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Divi	tal or Atrs after dal Directed in by	Certifi	4  Homicide determined	building,	etc. (Specify)		eet, factory, office		City or To	wn, State	o) 	Rural Route Number,
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	Str	ate	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature		Caton	AV	e, 130	itti	une	MD

DHMH 17 Rev 1/2001

Frank

ORIGINAL

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			Negistrar     Necedent's Name (First, Middle)	die, Last)			0 01 00		2. Date of De			3. Time of Death
	Physici /Medio		Marie Barbara	Foltz					Month 12	03	2004	5:20 AM M
	Examin		4a. Facility Name (If not institution			4b. City,	Town, or Lo	cation of Deat			County of Dea	
		*	Manor Care of	+			Ltimor				Baltimon	
	Funeral		5. Social Security Number	6. Sex 7. Age 1 ☐ M 2 X F	e (In yrs. last bir	Yrs. If Under		Under 24 Hrs Hours Min.	(Month, Da		9. Bir	thplace (State or Foreign ountry)
٠,	Director		217-34-7701 Usual Residence of Decedent		89				02/24/	1915	Ma	ryland
	ylanc how		10a. State 10b. Count	у	10c. City, Town	n or Location						10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or Items 23e or 28e-1 show avent, the Mcdical Examinet must be multied at	Director	10e. Street and Number			10f. Zip	Code				izen of What C	ountry?
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	fter de	Funeral	11. Marital Status  1 □ Never Married 2 □ Ma	Armed Forces?		If Yes, spec	offy Cuban, N	Mexican, Puerl	pecify Yes or No o Rican, etc.)		Black, Whi	
8	el', o	by	3 X Widowed 4 □ Divorce			1 ☐ Yes	2 <b>X</b> No S	Specify:			Specify: Wh	nite
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ary	should by and Menta is marked sumatic ay	-	19a. Informant's Name/Relation	2	19b	. Mailing Address			Newbau ural Route Numb		r Town, State,	Zip Code)
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altimore,	of Head		20a. Method of Disposition	a 3 □Removal from State	20b. Place of cemeter	Disposition (Namey, crematory or o	ne of	-	Date		cation - City or	
Ĕ	Pages ment of tant: If it		`4 Donation 5 Dother (	(Specify)	Parkw	ood Ceme	tery	12/0	6/2004	Ba	altimor	e, Maryland
Bail	permit. Pages Department of Important; If i any injury or once.		21. Signature of Funeral Service	$\sim \rho$		22. Name an		, نا				al Home, P.A.
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	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	ical	(Check only 2 Medica	ring Physician: To the best of al Examiner: On the basis of	examination and	e, death occurred d/or investigation.	at the time, o	date and place on, death occu	e, and due to the arred at the time,	cause(s)	and manner as	s stated. e to the cause(s)
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	B		30. Name and address of perso	n who completed cause of d	leath (Item 23a) (		UT"	4604			. (,	
	()		MICHAELS	( ' -		45EOUT	> Rd	七井,	131	محترا	MORE	Marylans
	Sta		31. Date filed (Month, Day, Yea		ar's Signature	1						
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			Decedent's Name (First, Middle, Last)					2. Date of Dea		Year 3. Time of I	Death
	Physicia /Medic	al	Michael Edward Frisby					Decembe	er 4, 20	004 547 a	М
2	Examin		4a. Facility Name (If not institution, give street and number)  Johns Hopkins Bayview			Town, or time	Location of Deat	n	4c. County	of Death	
4709	Funeral Director		215-86-4184 kg⋅м 2□F 28	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Da 6/7/19	h y, Year) 976	9. Birthplace (State or Country) Maryland	Foreign
	and		Usual Residence of Decedent  10a. State 10b. County 10c. (	City, Town or Lo	cation					10d. Inside City	y Limits
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	r 28a	rec	10e. Street and Number		10f. Zip	Code			10g. Citizen of V	What Country?	
	h with	Funeral Director	5919 Cedonia Avenue			212	06		U.S.	Α.	
	ems a	iner	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	lent of Hi	spanic Origin? (S n, Mexican, Puer	pecify Yes or No o Rican, etc.)	- 14. Race Blac	e - American Indian, ck, White, etc.	
036	urs after al', or its Framin	by	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes		Specify:			White	
5-0	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	kind of wor	k done c	during most of wo	rking	16b. Kind of Bu	usiness/Industry	
2	ithin ne.	Jg L	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT us	se retired	)		0.		
2	lled w lygier lher ti		17. Father's Name (First, Middle, Last)	500	ck Pe	rson	18. Mother's Na	me (First, Middle,	Sto:		
anc	id be fi ental H ked ot ic sver	To Be	Leo Maurice Frisby					Hoopes		-,	
Maryland 21215-0036	nd 2 shou Ith and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type, Print) Leo Maurice Frisby/Father							State, Zip Code) land 21206	
Baltimore,	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic svent, I've Medical Examinat must be notified at ance.		1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State Mt	Place of Dispo cemetery, ere Comfo alto./W	rt Cr	ther plac	$\frac{12-7}{12}$	Date 7-04 79/04	lexandr	City or Town, State ia, Va Maryland	
Balti	permit. Departm Importa any inju		21. Signature of Funeral/Service Licenses							neral Home and 21206	Inc.
			23a. Part1. Enter the disease of complications that caused the de shock, or heart failure dist only one cause on each line.							Approximate Interval Betw	ween
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Ξ	Physician: this certificatal cirector, p	ToB	examiner?   ★ Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 <b>X</b> DC	Oth Oth	er: 4 Nursing	Home 5 ☐ Resi	dence 6 Oth	er (Specify)	
o uo	Wite		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury Found 12-4-2004	Found 5:30	M A	8c. Injun Wor			how injury occurr		
Divisi	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	ertification:	3 Suicide 4 Homicide  6X Could not be determined  28e. Place of Injury - A building, etc. (Special County)	t home, farm, st	reet, factor			28f. Location ( City or Ton Baltimo	wn, State) 501	per or Rural Route Numb 9 <b>Cedonia</b>	Ave.,
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	To th within To th comp	Me	29b. Signature and title of certifier	W		c. Licenso	e number			d (Month, Day, Year) 5, 2004	
			30. Name and address of person who completed cause of death (	tem 23a) (Type	Print 111	Per	n Stree	t, Baltin	more, MD	21201	10*0.0
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Si	gnature	,	,					
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ORIGINAL

		1	For Stete Registrar					/ Depa		t of H	ealth a		lental Hy		nnı		779
	Physicia	n	1. Decedent's Name (First, Midde CRYSTAL DANA		 Y								2. Date of Dea Month	ath Day	Yea	3. Time of	Death
	/Medica Examine	r	4a. Facility Name (If not institution  SAINT AG  5. Social Security Number		treet and num	UTH	CALC.	Est birthday)	4b. City,	BAL	Location of	OR	E	4c. C	N/A		
	Funeral Director		218-90-0629 Usual Residence of Decedent		M 21XF		40	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) 2-24-1	964	MA	ARYLAND	
	se Marylan	ctor	MD. 10b. Count			1		Town or Lo	RE							10d. Inside Ci	
	3a or 2	Dire	10e. Street and Number 4016 PENHURS	T AV	Ε.				10f. Zip	Code 21215	5			-	en of What JSA	Country?	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I a Modical Examinar must be notified at once.	2	11. Marital Status  1 □ Never Married 2∑ Ma 3 □ Widowed 4 □ Divorce	rried 1	2. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	rces? 2∭XNo ′e	er in U.S.	+	Was Decedif Yes, specific			gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)		4. Race - Ar Black, Wi Specify: I		
Baltimore, Maryland 21215-0036	within 72 hound.	Completed by	15. Decede (Specify only high Elementary/Secondary (0-12)	est grade	completed)  College (1	-4or 5+)		16a. Deced (Give life.	dent's Usua kind of wo DO NOT u		ation furing most )	t of work	ing		d of Busines	,	
land 2	lid be filed vental Hygis ental Hygis kad other t ic evant, th	To Be Co	17. Father's Name (First, Middle WALTER J. GF					CI	LKIU	AL	18. Mothe	r's Name	e (First, Middle,				
, Mary	and 2 should alth and M M 27 is mar er traumati		19a. Informant's Name/Relation					3000	TOW.	ANDA	AVE.		309 BA	LTIMO	DRE, N	IARYLAND	2121
imore	Pages 18 ment of He ant: If itam ury or oth		20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other	Specify)		Sizie	KING	ce of Disponetery, crer	DRIAL	PARE	X 1	2-11		BALTI	MORE,	or Town, State  MARYLAI	ND
Balt	permit. Par Departmen Important: any injury once.		21. Signature of Funeral Service		).	riBi	w	) 17	721-2	7 N.	MONR	OE S	T. BALT	IMORE		ME, P.A. RYLAND 21	1217
760,	ysicia ysicia	cal Ex	23a. Part / Enter the disease, sho /k or heart failure. Li Immediate ause (Final disease / condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it jury that initiated events resulting in death) Last	a a b	Due to (	(or as a c	conseque	nce of):	nce		y, Suuli as	Cal Glack	от геориалогу ат	iest,		Approximatinterval Bat Onset and I	ween Death
.O. Box 68	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼ Unknown	23	3c. If yes, out 1 □ Live b 4 □ Pregn 9 □ Unkno	irth 2 ant at tir	☐ Fetal d	eath 3	Ectopic p Other (sp					23	3d. Date of o		Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant condi	tions con	tributing to de	eath but	not result	ing in the u	nderlying o	ause give	en in Part I.	,			e contribute	to the cause of d	death? Jnknown
Red	(G CT	Completed											24a. Was autop perfo 1 Yes	an sy med?	24b. Were prior to death		available ause of
ر کر Vital	ician: sertific ector,	o Be (	25. Was case referred to medic examiner?  1 Yes No	_	ospital:		ÀD/E	R/Outpatier		Othe	200		n (Check only o		D0:5 /0		
K FL	Attanding Phya it death. actor: After this of by the funeral dir	H +	27. Manner of eath  1 Natural 5 Pend 2 Accident invest	tigation	28a. Date	Inpatient of Injury th, Day Y	2	8b. Time o		28c. Injury Work	at at		28d. Describe h			респу)	
	a Hospital or Attand 124 hours after death e Funaral Diractor: letely filled in by the	Certification	4   Homicide	mined		ng, etc.	(Specify)						City or Tox	m, State)		Rural Route Num	b⊕r,
	5550	Medical	29a. Certifier (Check only one) 1 Certify Medical Medi	el Exemir	icien: To the ner: On the ba and mani	asis of e	xaminatio	edge, deat on and/or in	vestigation	, in my o	ne, date an pinion, dea e number	d place, th occuri		date and p	place, and d	as stated. lue to the cause(s onth, Day, Year)	)
	1318		30. Name and address of person	lo	ACMV Inpleted caus	2 /	NL th (Item 2	23a) (Type.	Print)	1700	558	49		200	ember	15, 200 18. Itimo	54
3	Stat		Scott Berge 31. Date filed (Month, Day Yea	Ir)	57/	Agn	es s Signatu	Hom	-11	1/05%	rital	90	10 Cato	n Au	enve	B. Itima	rein
	Registra	ır	DEC 0 8 2	.004	124	Carlotte Comment	1		Sport.	la!							

				ificate of Death	Reg. No.? 111, 29700
г	Physici	an	Decedent's Name (First, Middle, Last)  Classification  Cl		Date of Death Month Day Year
	/Medi Examir		Charles C Gero	4b. City, Town, or Location of Death	ovember 30 2004 2:11 A <sup>M</sup>
	Exami	ići	Frederick Memorial Hospital	Frederick	Frederick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8 D	Date of Birth 9 Birthplace (State or Foreign
	Director		176-20-9983 X Yrs.	Jai	m. 22, 1925 Pennsylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	ition	10d. Inside City Limits
	Mary B-feh	tor	Maryland Frederick F	Frederick	- 1 <b>∑</b> Yes 2 □ No
	th with the 23a or 286	Funeral Director	10e. Street and Number 210 West 12th Street	10f. Zip Code 21701	10g. Citizen of What Country? U.S.A.
336	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: if item 27 is marked other then "netural", or items 23a or 28e-f ehow injury or other treumetic event. It is Madical Example to unal be notified at 6.	by Funer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	as Decedent of Hispanic Origin? (Specify res, specify Cuban, Mexican, Puerto Ricar Yes 2 X No Specify:	Yes or No- n, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
5-0036	72 hou	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir	nt's Usual Occupation	16b. Kind of Business/Industry
2121	ithin 7	nple	Elementary/Secondary (U-12)   College (1-4or 5+)	nd of work done during most of working O NOT use retired)	
	iled w tygier her th	Co		nical Engineer	Steel Industry
anc	d be fa	To Be	Classal and Consider	Ella Sho	st, Middle, Maiden Sumame) OUTEK
Maryland	d 2 shoul th and Me 27 is mark treumeti	Ĕ		Address (Street and Number or Rural Rollast Second Street,	ute Number, City or Town, State, Zip Code) Frederick, MD 21701
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 eny injury or other tr once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition semantic, cremation, cremation.	ion (Name of Date tory or other place) emorial Cemetery Dec	20c. Location - City or Town, State c. 4, 2004 Pittsburgh, PA
Balti	permit. Pag Department Importent: I eny injury c		21. Si ya ure of Funeral Service Licensee MOOO2 22. K	yame and Address of Facility Keeney and Basford I 106 East Church Stre	
8760,	The law requires that the death certificate be executed was been signed by the attending physician and up of contains and up of	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	THRIVE	Approximate Interval Between Onset and Death  The Property of the Control of the
9	rtifical ng phy as th	Medi	IF FEMALE:		
O. Box	that the death cer ed by the attendin detached for use	ysiclan/	23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   2   Unknown   2   Unknown   3   Edward   3   Edward   4   Pregnant at time of death   5   O	ctopic pregnancy hther (specify)	23d. Date of delivery  Month Day Year
Д	w requires that the been signed by should be detac	Completed by Physiclan/Med	Part II. Other significant conditions contributing to death but not resulting in the under the moves; and AV MALFOR	erlying cause given in Part I. R MATIOレ	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,	: The law i cate has be page 2 sh	Comple	`		24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No
Vita	Phyeicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Che	
ō	Phyer this ral di	. To	To tes 2010 Tempatient 2016/Outpatient	3 DOA 4 Nursing Home	5 Residence 6 Other (Specify)  Describe how injury occurred
lon	th. : Afte	tlon	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	28c. Injury at Work?  M 1 \( \sup \text{Yes} \) 28d. I	Social non injury occurred
Division	al or Attending is after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	I, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or invessional manner stated.	ccurred at the time, date and place, and d stigation, in my opinion, death occurred at	lue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
	To t Within	M	29b. Signature and title of certifier  (W2n	29c. License number  D 00 47951	29d. Date signed (Month, Day, Year) 11- 30 - 200 +
	4		30 Name and address of person who completed cause of death (Item 23a) (Type, Pri SIBTE A. KAZMI, ND 814 TOLL HOUSE		K, MD 21701
C <sub>1</sub>	Sta Registr MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	Sporter	

ORIGINAL

		ı	For State Registrer	State of M	aryland / Depa <i>Ce</i> a	artment of h		-	giene Reg. No. 0 0 1	38781
			1. Decedent's Name (First, Middle	, Last)				2. Date of De.		3. Time of Death
	Physici /Medic		Irving W. Gro	oat Sr.				12	CDay 20	(ear 4 9:30 AM
	Examin		4a. Facility Name (If not institution	give street and number)	0	4b. City, Town, o	or Location of Death	2	4c. County of	Death
			Hanklin so	hare to	Stital	KOSG	5901-	<u></u>	13211	-imole
	Funeral		5. Social Security Number 068-18-4447	6. Sex 7. Ag	ge (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th y (1 0 7 6	Birthplace (State or Foreign Country)     New York
	Director		Usual Residence of Decedent		70			11/11/	1920	New IOLK
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mar-fat	tor	MD Bali	imore	Notting	ham				1 □ Yes 2√√No
	or 28	)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath w	Funeral Director	105 Leslie Aver	nue		2123			U.S.A	•
	er de	nne	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of his Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Black,	American Indian, White, etc.
36	rs aft	by F	1 ☐ Never Married 2 🖾 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tx Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
215-0036	72 hours after death with the Maryland natural', or items 23e or 28a-f show dical Executed and be mailfied at	ed	15. Decedent		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	ness/Industry
215	nin 72	piet	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or	(Give	kind of work done DO NOT use retire	during most of work d)	ing		,
212	filed within Hygiene. Ither than ant, the Man	Completed	12	College (1-40)		t Crew Fo	reman		Baltimo	re County
p	should be filed within 72 hours after death with the Marylan of Mental Hygiene. markad other than "natural", or flems 23e or 28a-f show markad other than "natural", or flems 23e or 28a-f show marked other than "nation and market harming and	Be C	17. Father's Name (First, Middle,	.ast)					Maiden Sumame)	
yla	Ment Ment arkac	To	William Groat				Marguer	ite Gat	es	
Maryland 21	ल ∞ ⊇		19a. Informant's Name/Relations				and Number or Run			
	of Health of Health itam 27 I		Martha S. Groat	:/Wife	20b. Place of Dispo		renue Balt	imore,		
0	(D) (C) was been		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation	3 □Removal from State	cemetery, crei	natory or other pla	ce)		20c. Location - Ci	
Baltimore,	oermit. Pag Department mportant: I eny injury o		4 ☐ Ponation 5 ☐ Other (S) 21. Signature of Fureral Service		Dulaney '	-	12/10			re, Maryland
Ba	permit. Page Department Important: If eny injury o		21. Signature of Fu era Bervice	licensee	6	415 Belai	ess of Facility Mil Er Road Ba	ler-Dip ltimore	pel Fune: Maryla	ral Home Inc. nd 21206
			23a. Pa 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each l	d the death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Imm di te Cause (Final disease or condition	Right F	Sontofa (it	to In	+ Co-Clay	in He	marcha	Onset and Death
•	/Medical Examiner		resulting in death)	Que to (or as	a consequence of):					
H.	LAdimine		Sequentially list conditions.	b. V//\						
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
_	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c	a consequence of):					
8760,	cate be executed physician and the burial-transit	<u>e</u>								
687	ficate g physi as the b	edicai		0.						
Box	The law requires that the death certific te has been signed by the attending to agge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of	of delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		Ectopic pregnancy Other (specify)	y 		Month	Day Year
P.0	at the de by the a tached t	hys	9 🗌 Unknown	9□ Unknown						
	es tha gned be del	by F	Part II. Other significant condition	ns contributing to death t	out not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	67	ute to the cause of death?
ord	equir en si ould							1 🗆 Y	/es 2/□No 3	☐ Probably 4 ☐ Unknown
Records,	e law re has be je 2 sho	ompieted						24a. Was autop		re autopsy findings available or to completion of cause of
=		Cou								ith? Yes 2□ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospitali		0.1	26. Place of Deatl	Check only o	ne)	
of	Physithis all dir	2	1 Yes 2 No	Hospital:			4 Nursing Ho		lence 6 Other	(Specify)
UC	ing After uneu	ion	1 ☑ Natural 5 ☐ Pendin		ury 28b. Time of 1y Year) Injury	Wor	rk? Yes 2 □ No	zad. Describe r	now injury occurred	
Division	of or Attanding affer death. Diractor: After In by the fune	lical	3 ☐ Suicide 6 ☐ Could r	ot be an Blace of la	jury - At home, farm, str			28f. Location (S	Street and Number	or Rural Route Number.
ρ		Certification:	4 ☐ Homicide determ	building, e	tc. (Specify)	oot, tablety, office		City or Tow		or resident and or,
	To tha Hospitel or At within 24 hours after of To the Funaral Dirac completely filled in by	edical C	(Check only 2 Medicel	g Physicien: To the best examiner: On the basis of	of examination and/or in	n occurred at the til vestigation, in my o	me, date and place, opinion, death occurr	and due to the dred at the time, d	cause(s) and mann date and place, and	er as stated. If due to the cause(s)
	To tha within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner st	ated.					
	⊬ ≱ ⊢ ୪		W 5	0 () U.	200	HO	060516		12/1/2	11
	1 Kai		30. Name and address of person	who completed cause of	death (Item 23a) (Tune	Print)	-60016		12/0/0	7
	10.1		A	olikows Kig	000 Frank	in 50 wa	060516 - [ B B D ] )	timor	e, MD	21237
	Sta		31. Date filed (Month, Day, Year)		rar's Signature	land.	/		,	
	Registr	ar	DEC 0 8 2	UU4 Jan Pre		pysources				

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12/15/04 TT State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 08 ZDO4 planche Go HMan 1:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Riverview Care Center & Rehab Essex Baltimore 7. Age (In yrs. last birthday) 91 Yrs. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🛣 F 004-26-2988 Director Maine Usual Residence of Deceden 1913 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumetic event, the Wedical Examination 1 and be partitled. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. Baltimore Director Essex 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Brette Ct. Apt. 215 21221 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ģ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Health Care Provider Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Cook Mary Pomerleav 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude Nunnan / Daughter 69 Oak St., Waterville, Maine 04901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Balto-Wash. Crematory 12-6 -04 Laurel, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton-Matthews, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertensia Actorioscionatic Cormany V moube Dinaec Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Old Cerebro \* Aswlon acaident 1 Yes 2 No 3 Probably 4 Onknown Insullicience 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2- No Division of Vital 1 Yes 1 Yes or Attending Physicien: in by the funeral director, 25. Was case referred to medica examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) filled within 24 hours a To the Funeral I To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Herchael D19667 11-18-2004 Cenames 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7310 Ritchie Hochenson Ti'lled The act of \$508 Glan Borine, Maryland 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

DEC 0 8 2004

oaks

			- State	of Maryland / Depa	artment of F			2001.	38783
			Registrar  1. Decedent's Name (First, Middle, Last)		Timeate of I	Deain	2. Date of Death	1. NG. UU4	3. Time of Death
	Physici		Karl A.W. Heymann				Month December	7, 2004	5:50 a M
	/Medio Examin		4a. Facility Name (If not institution, give street and no	umber)	4b. City, Town, o	r Location of		4c. County of Dea	
	Examin	ei	1006 Green Hill Farm F			erstown		Balti	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birth	0.00	thplace (State or Foreign ountry)
	Director		219-22-1502 <sup>1⊠M 2□F</sup>	77 Yrs.	Months Days	Hours	Min. (Month, Day, ) July 28,	1927 Ma	ryland
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lc	antion				10d Incide City Limite
	anyla shov	7	,	Toc. City, Town of Et					10d. Inside City Limits 1 ☐ Yes 2∑ No
	he M	Director	Maryland Baltimore		Reister	stown	10.	Citizen of Miles O	
	a or		10e. Street and Number	D 1	10f. Zip Code	0.6	10	j. Citizen of What C	ountry?
	eath	era	1006 Green Hill Farm  11. Marital Status 12. Was De		211		n? (Specify Yes or No-	U.S.A.	erican Indian
<b>'</b> 0	fter dea	Funeral	Armed F		If Yes, specify Cuba	an, Mexican, I	Puerto Rican, etc.)	Black, Whi	te, etc.
036	urs a	ρ	If Yes. G	live Dates: WW II	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
0-10	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-1 show Ita Madeal Examil et mat Le mallied at	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Dece	dent's Usual Occup	ation	of working	3b. Kind of Business	/Industry
2	thin to the total the tota	npie		(1-4or 5+)	kind of work done of DO NOT use retired				
21	ygien ygien yer th	Co	4	Elec	trical En			B.G.E	•
pu	be fill tat H d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, Middle, Ma	iden Sumame)	
7 3	12 should be filed within n and Mental Hygiene. 7 Is marked other than "raumatic avent, the Max	မ	Heinz Heymann				lary Logis		
Maryland 21215-0036	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print)				or Rural Route Number,		
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itama 23a or 28a-1 show other traumatic avent. Ite Medical Examiler mast be multiled at		Celeste A. Heymann Wi	20b. Place of Dispo	Green Hi	!		sterstown Oc. Location - City o	MD 21136
Baltimore,	Pages nent of h ant: If its ary or o'	1 9	1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from	n State cemetery, cre	matory`or other plac	1			
븚	iit. P.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		w Mem. Pa 2. Name and Addre				, Maryland
Ba	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		Stephen M Je	1			11824 Rei me Reister		
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not en					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		OMYOP	ATH	<u> </u>		Onset and Death
	/Medical		resulting in death)	(or as a consequence of):		, , , ,	•		
	Examiner	U	Sequentially list conditions, b.						
	ad sit	Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):					
	and I-tran	хап	that initiated events c.	(or as a consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	alE		. (					
687	licate phys s the	edical	d						
Box (	eath certific attending p	Physician/Me		utcome of pregnancy				23d. Date of de	livery
ă	death a atte	ciai	in the past 12 months?	nant at time of death 5	⊒Ectopic pregnancy ⊒ Other (specify)			Month	Day Year
0	that the de led by the a detached	hys	9 Unknown 9 Unk	nown					
S, P	es tha igned be det	by P	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
rd	w require been sig should b				<del></del>		1 ☐ Yes	2 <b>□</b> No 3 □ P	robabły 4 🗆 Unknown
of Vital Record	e law re has bei je 2 sho	Completed					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Ě	The laste ha	E O					performe	d? death?	s 2 No
ita	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?			26. Place o	f Death (Check only one)		
₹	hys his II dii	2	1 ☐ Yes 2 ☑ No ☐ Hospital:	Inpatient 2 ER/Outpatie		4   14012		ce 6 □Other (Spe	ecify)
	ing P	on:	Natural 5 ☐ Pending (Mo	of Injury nth, Day Year) 28b. Time of Injury	Wor		28d. Describe how	injury occurred	
Sio	Attending ir death. ector; After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be 280 Block	an of laives. At home form at		Yes 2 □ No		et and Number or A	hand Doube Alamba
Division	al or Attending P safter death. I Director: After t d in by the funera	Certification:	4 Homicide determined 286. Plat	ee of Injury - At home, farm, st ding, etc. (Specify)	геет, гастолу, опісе		City or Town,	State)	urai Houte Number,
_	spital ours ours neral filled		29a, Certifier 1 Certifying Physician: To the	ne best of my knowledge, deat	h occurred at the tin	ne date and	place, and due to the cau	se(s) and manner a	s stated
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medicai	(Check only 2 Medical Examiner: On the	basis of examination and/or in nner stated.	vestigation, in my o	pinion, death	occurred at the time, dat	e and place, and du	e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1	29c. Licens	e number	290	I. Date signed (Mon	
)	ν.		I want	1 mg		9 2	4740	Dec. 8	th 2004
	$m_{\beta_1}$		30. Name and address of person who completed car		Print)			1	
	(V		THOMAS A- TRAIL		DHN? HO	PKINS	HOSPITAL	BALTIM	ore md
	Sta Registr		31. Date filed (Month, Day, Year) 32. DEC 0 8 2004	Registrar's Signature	1				
	negisti	-GI	2F0 0 0 7004	Mary Mary	Spark	2			

			For State C		artment of Health and Natificate of Death		ne No.2014	38701.
	Dissolution		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
4	Physici /Medic		David Humple			DECEMBER	<sup>25</sup> , 2004	5:26P. м
	Examir		4a. Facility Name (If not institution, give street and no ST.AGNES HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
	Funeral Director		5. Social Security Number  213-82-3459  Usual Residence of Decedent	7. Age (In yrs. last birthday)  31  Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 15,	ar) Coun	lace (State or Foreign try) MD
	/land		10a. State 10b. County	10c. City, Town or Lo	cation		1	Od. Inside City Limits
	a-fsh	tor	MD Carroll	Sykesvi	11e			1 ☐ Yes 2 X No
	or 28	Dire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
	ath w	rai	711 Central Ave.		21784		USA	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked othar than "natural", or itams 23a or 28a-f show or othar traumatic evant, the Modical Examinational perioritied at	by Funeral Director	Amed F	orces? I 2☑No ive	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	2 should be filed within 72 hours aft and Mental Hyglene. Is marked othar than "natural, or aumatic evant, The Modical Excuri	Completed	15. Decedent's Education (Specify only highest grade completed,	16a. Deced	tent's Usual Occupation kind of work done during most of work	ing 16b	. Kind of Business/Inc	
21	ithin and and and and and and and and and an	npie	Elementary/Secondary (0-12) College	1-4or 5+)	DO NOT use retired)	ang .		
121	iled w dygler thar ti nt. In		12 17. Father's Name (First, Middle, Last)	Ca	shier 18 Mother's Nam	e (First, Middle, Maid	onvenience	Store
and	d be f ental h	o Be				a Ann Beal	,	
Maryland	should not Me	2	Walter R. Humple, Sr.  19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Street and Number or Rur			Code)
	and 2 alth a 27 is		Walter R. Humple, Sr. I	ather 711	Central Ave., Syk	esville. N	D 21784	
ore	of He of He fitam roth		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □ Removal from	20b. Place of Dispo	sition (Name of natory or other place)	Date 20c	Location - City or To	wn, State
Ĕ	Pag ment ant: i		'4 □Donation 5 □ Other (Specify)		n Cemetery 12/	9/2004 I	Randallsto	wn, MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if itam 27 is any injury or othar trau 90.69.		21. Signature of Funeral Service Icens	n E	Name and Address of Facility  line Funeral Home	Reisters	eisterstow stown, MD	
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not ente each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	reumonia	J			5,100, 4,10 55411
	Examiner		Due to	(or as a consequence of):				
	T	ē	Sequentially list conditions, if any, leading to immediate Due to	(or as a consequence of):				
	cuted	Examin	cause. Enter Underlying Cause (Ciscase or injury that initiated events					
0,	e be executed sician and buriat-transit	EX	resulting in death) Last Due to	(or as a consequence of):				
8760	cate be ex physician the buria	dicai	d					
O. Box 6	w requires that the death certificate be execut been signed by the attending physician and should be detached for use as the burtal-tran	Completed by Physician/Me	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
Δ.	that the ed by detac	/ Ph	Part II. Other significant conditions contributing to c	death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
rds,	requires that the een signed by th nould be detache	ed b)	Renal failure, Hyp	ertensicon	, obesity	1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
Division of Vital Records,	e lav has je 2	complet			/	24a. Was an autopsy performed	24b. Were autop prior to con death?	osy findings available inpletion of cause of
/ita	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?			h (Check only one)		
of \	Physician: this certific ral director,	P	14∑ Yes 2 No	Inpatient 2 XER/Outpatien			6 Other (Specify	)
uc Ou	fter	ion:	TANALUIAI 3 1 BIIGING	of Injury oth, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
Sic	Attanding ir death. actor: After by the fune	fical	3 Suicide 6 Could not be 28e. Plac	e of Injury - At home, farm, str		28f. Location (Street	and Number or Rura	Route Number,
Ö	after after Dira d in b	Certification:	4 Homicide determined build	ling, etc. (Specify)		City or Town, St	ate)	
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Medical C	(Check only 2 Medical Examiner: On the I	e best of my knowledge, death pasis of examination and/or invented.	o occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cause red at the time, date a	o(s) and manner as stand place, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	4	29c. License number		Date signed (Month, I	
			I larve Hall	auand	O.C.M.E.	DEC	EMBER 6,20	004
	1		30. Name and address of person who completed cau		Print) 11 PENN STREET,BA	LTIMORE, MA	RYLAND 21	201
	Sta Registi		31. Date filed (Month, Day, Year) 32.1 DEC 0 8 2004	Registrar's Signature	& Sparks			

	1 - For State Registrar	State of Marylan	d / Department of Health ar Certificate of Death		2004 38785				
Physician /Medical Examiner	1. Decedent's Name (First, Middle, La:  Bey thu  4a. Facility Name (If not institution, give	M. Hof	4b. City, Town, or Location of	2. Date of Death Month Dec.	Day Year 3. Time of Death 4c. County of Death				
Funeral Director	5. Social Security Number 6. S	29 h Ø (; a /f) ex 7. Age (In yrs. □ M 2√2 F 90	last birthday) If Under 1 Year If Under 24  Yrs. Months Days Hours	Hrs. 8. Date of Birth Min. 10-20-19	Balling State or Foreign (State or Foreign Country)  Maryland				
the Maryland 286-1 show colified at	MD 10a. State 10b. County Baltimor		y, Town or Location  ay  10f. Zip Code	100	10d. Inside City Limit 1 ☐ Yes 2 ☐ N				
72 hours after death with the Maryland neturel; or items 23a or 28a-1 show dical Exacting must be notified at deed by Funeral Director	1734 Magnolia Ave  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1Yes _2\frac{1}{2}No If Yes, Give Year or Dates:	21227	? (Specify Yes or No-	. Citizen of What Country?  S . A .  14. Race - American Indian, Black, White, etc.  Specify: White				
d 2 shours all the and Mental Defined within 72 hours all the and Mental Hygiene. 27 is marked other then "neturel", or treumatic event, the Medical Evant To Be Completed by F	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de <i>completed)</i> College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most o life. DO NOT use retired)  AVON Lady	f working	b. Kind of Business/Industry				
12 should be filed within hand Mental Hygiene. 7 is marked other then "I treumatic event, the Men To Be Comple	17. Father's Name (First, Middle, Last)  George Wagner  19a. Informant's Name/Relationship (7)	iypə, Print)		Name (First, Middle, Maiden Sumame)  Hutton  r Rural Route Number, City or Town, State, Zin Code)					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-1 show any injury or other treumatic event, the Madical Examinar must be notified at once.  To Be Completed by Funeral Director	Melton L. Hoffman  20a. Method of Disposition  1 □ Burial 2 ☼ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Sign tule) if Fun 7a Service Licen	Removal from State Ba	1734 Marnolia Ave. Relace of Disposition (Name of ametery, crematory or other place)  yview Crematory 12	elay MD 212 Date 200 -06-04 B	27 c. Location - City or Town, State altimore, MD				
Fnysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line.  a	Ambrose Funeral 1328 Sulphur Spr. Do not enter the mode of dying, such as call the superscript.	ing Rd Arbu	Approximate Interval Between Onset and Death				
cate be executed physician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	rence of):	, veder co					
the death certific by the attending pached for use as ached for use as hysician/Mec	in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	déath 3 □ Ectopic pregnancy ath 5 □ Other (specify)		23d. Date of delivery Month Day Year				
w requires that been signed b should be det	Part II. Other significant conditions co	ntributing to death but not resu		d tobacco use contribute to the cause of death?  ☐ Yes 2 图 No 3 ☐ Probably 4 ☐ Unknow					
	25. Was case referred to medical		24a. Was an autopsy performed 1 Yes 2						
hys this al did	examiner?		Other		ne 5 Residence 6 Other (Specify) 188. Describe how injury occurred				
ospital or Attending P hours after death. unerel Director: After ty filled in by the tunere cal Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify,	ne, farm, street, factory, office	City or Town, S					
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by Medical Certifi	(Check only one)  2 Medical Exam  29b. Signature and title of certifier	ner: On the basis of examinati and manner stated.	ccurred at the time, date	and place, and due to the cause(s)  Date signed (Month, Day, Year)					
State	30. Name and addres per non oc Jeffy 31. Date filed (Month, Day, Year)	om leted cause of death Item  32. Registrar's Signatu	23a) (Type, Print)  MD 3 7 7 9 W  June	Hiers A	12/3/94 ve Bult, Mel 21.				

			1 - For State Registrar	State	of Ma	ryland / De <i>C</i>	•	ment of icate o			d Me	_	giene Reg. No			
	Physici		Decedent's Name (First, Midd.     Ronald Harris	le, Last)								2. Date of De Month December	ath Da	2004	Year	3. 1000 ft 18ats 11:25 P M
	/Medic Examin		4a. Facility Name (If not institution Joseph Richey Hosp		ımber)		4b	. City, Towr Balt		ocation of D					of Death	1
	Funeral Director		5. Social Security Number 216–60–5786	6. Sex 1 X M 2 ☐ F	7. Age	(In yrs. last birthdo	Mo	Under 1 Ye onths Day		If Under 24 I Hours N	Hrs. 8 Min. 0	3. Date of Birt (Month, Da 19-11-19	th y, Year) 46		9. Birth Cou Mary	place (State or Foreign ntry) Land
	show		Usual Residence of Decedent  10a. State 10b. County	,		10c. City, Town or	Location	on								10d. Inside City Limits
	a Man 3e-f sh tiffed	Director	MD	NA			В	altimor	re							1MYes 2 No
	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23e or 28e-1 show ent, the Medicel Examiner must be notified at	Dire	10e. Street and Number 1243 Woodbourne	Avenue			1	Of. Zip Code	e 2123	39			10g. Cit		What Cou USA	ntry?
	death	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ev	ver in U.S. 1	3. Was	Decedent of	of Hisp	panic Origin?	? (Speci	ify Yes or No ican, etc.)	-		e - Ameri ck, White,	can Indian,
36	rs after I', or Ita	by Fu	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 Yes	2 KN No ive			Yes 2. 1 Yes		Specify:	3011011	our, o(c.)		Specify	<i>y</i> :	
5-0036	72 hou natura lical E		15. Deceder	nt's Education		16a. De	cedent'	s Usual Oc	cupati	ion	working		16b. K	ind of B	Blac usiness/Ir	
721	s within 72 piene. r than "n	Completed	Elementary/Secondary (0-12)	College		) life		votuse rei		ring most of	WOIKING	,			NA	
₹2		a	17. Father's Name (First, Middle,	Last)			14	CVCZ 110			Name (	First, Middle,	Maiden	Suman		
yland		To B	Raymond Harris									skervil				<u> </u>
Mary	nd 2 should Ith and Mer 27 Is marke ? raumatic		19a. Informant's Name/Relations  Cynthia Harris-Mc		ter							Route Numbe timore,			State, Zij	Code)
ē,	es 1 and 2 of Health ( I item 27 li r other tra		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation			20b. Place of Discemetery, of	spositio	n (Name of			Dat				City or To	own, State
AS Pro-Baltimore,	Pag nent ant: I		* 4 ☐ Donation 5 ☐ Other (5	Specify)	State	Metro Cre		,		i	08-04		Cato	nsvi	lle, M	ID
Bal	permit. Page Department Importent: any injury once.		21. Signature of Funeral Service	Licensee	•			me and Add e Funer		•	38 N.	Gilmor	Stre	et Ba	alto.	MD 21217
	*		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that only one cause on	caused to											Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-		15 OF (	40	ER								YEARS
	Examiner			Due to	(or as a	consequence of):	8170									LEARC
7	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a	consequence of):							20c. Location - City or Town, State Catonsville, MD r Street Balto, MD 21217			
0,	e be exacuted rsician and e burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a	consequence of):										
5/	# % B	cal		d												
الا مر الا مر	leath certificat attending phy I for use as th	/Мес	IF FEMALE:	23c. If yes, ou	itcome o	f pregnancy							"" T	334 Dai	to of delive	201
) 0. Bo	it the death by the atten tached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	birth 2 nant at ti	Fetal death		opic pregna ner (s <i>pecify)</i>								,
30.	s that the ned by a detac	by Ph	Part II. Other significant conditi	ons contributing to	ieath but	not resulting in the	e under	lying cause	given	in Part I.		23e. Did to	obacco u	ise cont	ribute to t	he cause of death?
2 g	The law requiras that the death certificate has been signed by the attending phage 2 should be detached for use as the			G ABUS	SE	, HUX	IAN	/mm	UNO	DEFIC	TENC	10Y	es 2	□No	3 ₽rot	pably 4 Dunknown
T Rec		Completed	VIRUS INFECTION							_	autopsy prior to performed death?			oriar to ca	psy findings available mpletion of cause of 2 No	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital					2 Other:			Check anly o				11-00
9 6	ding Phys h. After this funeral di	n: To	27. Manner of Death	28a. Date		t 2 ER/Outpa 28b. Time Year) Injur	e of	28c. lr		at		d. Describe h				MACSPICE
Sion	Attendir death. ctor: Af y the fur	ertification:		igation not be				M 1	□ Ye	s 2 No		( )				10
ON IN	spitel or Atteno ours after death nerel Director: filled in by the	Certif	4  Homicide determ	nined   288. Plac	e of injur- ling, etc.	y - At home, farm, (Specify)	street,	factory, office	ce		28	City or Tow			er or Hura	I Route Numbers
\	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical one)	ey Physician: To the Examiner: On the I and mar	a best of e pasis of e nner state	examination and/or	ath occ r investi	gation, in m	a time, iy opin	, date and pr nion, death o	ace, and	d due to the d at the time, d	ause(s) date and	and ma I place, a	inner as s and due to	ated. o the cause(s)
	Tot withi Totl	W	29b. Signature and title of certifie	1 m	D			29c. Lice			632					Day, Year)
	11		30. Name and idd ess of person	who completed cau	se of dea	ath (Item 23a) (Typ	oe, Print	1)				27 =	400	2	O e town	
	Sta	te	31. Date filed (Month, Day, Year	855 ML	). Registrar	COLLA C's Signature	MY	PFIR	E,	C 04	UME	YA, N	D.	210	145	
8	Registr		DEC 08	2004	even	a by		1	2							
DH	HMH 17 Rev 1/2	001				1	PRO	y court	2							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 25 2004 2:00pm Nov. Charles David Hemler, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford 1309 Ontario Street Havre de Grace If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/12/1933 Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F Maryland 71 Director 217-28-6021 Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State worle s 23a or 28a-f shov 1XYes 2 □ No Director MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1309 Ontario Street Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 3 eny injury or other traumatic event, the Medical Examinet once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. No lif Yes 2 No lif Yes, Give Year or Dates: 35 years 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **National Guard** Security Guard 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ella M. Warthen Charles David Hemler, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Ontario St., Havre de Grace, MD 21078 Ruthe Hemler- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harford Mem. Grdns. 11/30/04 Aberdeen, MD 4 □ Donation 5 □ Other (Specify) Name and Address of Facility Mitchell-Smith Funeral Home, P.A. Signature of Funeral Service Licensee Mairl M 123 S. Washington, Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or and a consequence of): Oyears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 → Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 -NO or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Medicai Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊟Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel A: MD 21014 over Chesaparke Dr. 31. Date filed (Month DEC 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Marylar		rtificate of i		-	Reg. No.	004	3.8.7.8.8		
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Marlin Kroh Hoff  2. Date of Death Month November 28								3. Time of Death 8:15 AM		
	/Medic	al	4a. Facility Name (If not institution, give			Ab City Town or	Location of Death			2004			
Examin		er	1714 Hoke Road	New Win		1	4c. County of Death Carroll						
	Funeral		Social Security Number 6. S			If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			place (State or Foreig		
7	Director		Usual Residence of Decedent	KM 2□F 66		Months Days	Hours Min.	8. Date of Birl (Month, 9a June 7	, ' <b>1</b> '938		place (State or Foreig ntry) y Tand		
Marylan	Marylan e-f show	Funeral Director	10a. State 10b. County 10c. City, Town or Location New Windsor								10d. Inside City Limit		
th with th	23a or 28		10e. Street and Number 1714 Hoke Road		10f. Zip Code 2177	of What Cou A	ntry?						
ire ofter deet	be filed within 72 hours after death with the Maryland ntal Hygiene.  ad other than "natural", or items 23a or 28e-f show event, the Madical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 🕅 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No		1	14. Race - American Indian, Black, White, etc.  Specify: White				
within 70 ha		Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	dent's Usual Occup kind of work done o DO NOT use retired THE I	king	16b. Kind	-					
of the stand 2 should be filed of the stand 1 you will have a stand 1 you will have a standard or the standard control or other treumatic event,	To Be Co	17. Father's Name (First, Middle, Last) S. David Hoff			Miriam Kroh								
		19a. Informant's Name/Relationship (Ty Kathleen R. Hoff/			Hoke Rd.		indsor	-		o Code)			
	ayes I a ant of He t: if item y or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crer	sition (Name of matory or other place ek Cemete	θ)	Date	20c. Locat	ion - City or T	own, State		
a time	Departmen Departmen important: any injury once.		21. Signature of Furteral Service License		/ 22	2. Name and Address	s of Facility Ha	1	unera	1 Home			
	hysician /Medical		shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death		
a be executed	law requires that the death certificals been signed by the attending ph. 2 should be detached for use as the	Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect									
the death certifical			IF FEMALE: AJ/A 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 ☐ Feta	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown					23d. Date of delivery Month Da			
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										. Was an autopsy autopsy performed? Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
cian	entific actor,		25. Was case referred to medical examiner?	1-000	. all Doa Othe	th (Check only one)							
Phys rahis	tion: To	1 Yes No  27. Ivanner of Death  atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ome 5 Residence 6 □Other (Specify)  28d. Describe how injury occurred									
To the Hospitel or Attending	after death.  Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Hospits	within 24 hours a To the Funerel I completely filled	edicai C	29a. Certifier Check only one) 1 Certifying Physical Examination	sician: To the best of my knoner: On the basis of examina and manner stated.	ne, date and place pinion, death occu	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)							
Toth	within To the compl	Me	29b. Signature and title of certifier	1 ton-	tran	29c. License	1	29d. Date signed (Month, Day, Year)					
	6		30. Name and address of person who co			Print)	332,8	minat	///	07/0	7		
		te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		ngton Rd	West	minster	, MD 2	1157			

			For State Registrar		State of	Marylan		artmen rtificate			ind M		Reg. No	. 009		789
	Physicia	_	1. Decedent's Name	,								2. Date of De Month	Da	y Yea		of Death
	/Medic	al	Venora ( 4a. Facility Name (//	Frace Har		nber)		4b. City,	Town, or	Location o		PECENI		1, 200 County of De		10KM
	Examin	er	CITIZE		ING HO	_		HAUA	EPE	GRI	16.8		1.	INAFE	17	
	Funeral		5. Social Security N	umber 6.		7. Age (In yrs. 77	last birthday) Yrs.	1f Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. B	irthplace (Stat Country)	
	Director	}	235-38- Usual Residence of	2212		//	113,					12/5/1	926	W	est Vi	rginia
	yland		10a. State	10b. County		10c. Cit	y, Town or Lo	ocation								City Limits es 2 ☑ No
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	with the a or 2		10e. Street and Nur	nber Orsythia	Road			10f. Zip	1009	ı				J.S.A.	Country :	
	hours after death with the Maryland turel', or Itema 23s or 28s-1 show at Era' diver nust be notified at	Funeral Director	11. Marital Status	DISYCHIA	12. Was Dece	dent Ever in U	.S. 13.	Was Dece	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)			nerican Indian	,
9	or ita	F		ed 2 Married	Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 <b>K</b> No		1 ☐ Yes		Specify:	, 1 00110	riodii, oto.)			White	
9	hours tural',	ed by	3 <b>√2</b> ¥Vidowed	4 ☐ Divorced  15. Decedent's B		ates:	16a, Dece	dent's Usua	il Occupa	ition			16b. K	(ind of Busine		
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pu	be file	Be	17. Father's Name Roswell S			i11a						<i>(First, Middle</i> na <b>r</b> es	э, маюві	n Sumame)		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23s or 28s-1 show any injury or other traumatic event, the Madical Exa. illust coust be notified at anone.	၉	19a. Informant's N			LIIC	19b. Maili	ng Address	(Street a				per, City	or Town, State	, Zip Code)	
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Baltimore,	as 1 a of Head		20a. Method of Dis	position Cremation 3	□Removal from	State 20b. F	Place of Disponentery, cre	osition (Name matory or o	ne of ther plac	9)		Date	20c. L	ocation - City	or Town, State	
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Bal	parmit Depar Impor any in		21. Signature of Ft	ineral Service Lic	ensee		6	2. Name ar	A lat	r Ros	Mil	ller-Di	ppel	Funer Marylan	al Home	e Inc.
			23a. Part1. Enter the shock, or hea	he disease, or	chicalions that c	aused the deal	th. Do not en	ter the mod	e of dying	g, such as	cardiac o	or respiratory a	arrest,	larytan	Approxim	nate Between
	Physician		Immediate Cause disease or condition	(Final	, 5110 000000110		Se	bsi	\$							nd Death
	/Medical Examiner		resulting in death)	•	Due to (	(or as a consec	juence of):							-		
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Box 68	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, out	tcome of pregn		⊒Ectopic p						23d. Date of		
m m	death	sicia	in the past 12 1 $\square$ Yes 2	ØNo		ant at time of		Other (s)						Month	Day	Year
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1200	w requires been sign should be	lete			Chronic	At	rial	FIB-	511a	tien		24a. Wa		24b. Were	autopsy findir to completion	igs available
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	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by tha	Med	29b. Signature an	d title of certifier		2		29	c. Licens	e number				ate signed (M		r)
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/	0)		30. Name and ad	ss of person wh	no completed caus	se of death (Ite	m 23a) (Type	, Print)	4	ne		MD,	2	1078	2	
4	C+	ate	31. Date filed (Mo			Ragistrar's Sign	ave d	ce	,		)	111)				
	Regist		31. Date filed (Mo	JEC 082	2004	comme	1 19	Se	Or K	1/						

			State of Maryland / Department			ene	
			1 - For State Registrer Certificate	of Death		1.NZ U U 4	38790
ŀ	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)  Eugene Walter Holdiness	]	2. Date of Death	2004 Year	3. Time of Death 10:10 A M
	Examin	1000	, , , , , , , , , , , , , , , , , , , ,	own, or Location of Death		4c. County of Death Baltimore	2
	Funeral Director		5. Social Security Number 427-22-4764 6. Sex 1 XM 2 F 82 Yrs. 1 1 XM 2 F 82 Yrs. 1 1 XM 2 F 82 Yrs.	Days Hours Min.	8. Date of Birth (Month, Day, ) Dec. 16,		place (State or Foreign ntry)
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				Od. Inside City Limits
	Maryl	tor	Md. Baltimore Dundalk	:			1 ☐ Yes 21 No
	3s or 28s	al Direc	10e. Street and Number 1215 Ridgeshire Rd.	21222		Citizen of What Coul U.S.A.	ntry?
036	be filed within 72 hours after death with the Maryland that Hygiene.  ad other than "natural", or Items 23s or 28s-f show event. It a Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes 2 No If Yes, Specific Yes, Yes, Yes, Yes, Yes, Yes, Yes, Yes,	ont of Hispanic Origin? (Spe fy Cuban, Mexican, Puerto f No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 ho ene. than "natur re we Jicel	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12  16a. Decedent's Usual (Give kind of work life. DO NOT use Me chanic	done during most of working	ng 16	Repair Sho	
land 2	I Hygi other	To Be Co	17. Father's Name (First, Middle, Last) Featherston Holdiness	18. Mother's Name Omega	(First, Middle, Ma	uiden Sumame)	
<b>Jan</b>	12 sho			Street and Number or Rura			
ē,	Health tem 27	1	20a. Method of Disposition 20b. Place of Disposition (Name			c. Location - City or To	
imo	Page: nent or ant: If i		1 A □ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Gardens of Fai	th Cemt. 11-	30-04 B	alto.,Md.	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic e once.			Address of Facility  -Ashton-Matt	hews Fun	eral Home,	Inc.
760,	Medical Examiner buysician and buysician and physician and street burial-transit	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	· lenkenia.			proximate Interval Between Onset and Death
.O. Box 68	death certif e attending d for use as	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1			23d. Date of delive Month	ery Day Year
Δ.	es this	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cau			cco use contribute to the	
Vital Records,	(0) 1-1	Completed			24a. Was an autopsy performe	prior to co death?	psy findings available mpletion of cause of
Vita	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death			The state of the s
of	fter ne	tlon; To	1   Inpatient 2   ENOutpatient 3   DOA	and the second second second second	28d. Describe how		y)
Division	ial or Attendii s after death. al Director: A ed in by the fu	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office 2	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
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	To the 2	Σ	29b. Signature and title of certified 29c.	License number	Z 290	Date signed (Month,	Day, Year)
(	0 1 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Aly NAGUIB, MD. 1576	06659387 Merritt	Blud	.Ste#14	Balto, MD
-	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 8 2004  32, Registrar's Signature  Apon				

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			Decedent's Name (First, Middle, Las	it)					2. Date of De	ath - U	र्भ र्व	. Time of Death
	Physici /Medic		Lorraine	Izner					Decemb	$er^{Day}2,2$	0'0'4 9	:05 P.™
	Examin		4a. Facility Name (If not institution, give Gilchrist Care				-	or Location of Deat SON			of Death imore	
	Funeral Director		5. Social Security Number 213-30-0661 6. Security Number 1	ex 7. Age ☐ M 2☐¥F	e (In yrs. Ia 69	st birthday) Yrs.	If Under 1 Year Months Day		8. Date of Bird (Month, Da Mar 10	, 1935	9. Birthplace Country) Mary I &	e (State or Foreign and
2	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ation		-		10d.	Inside City Limits
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<b>9</b> 98	s after	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	No		☐ Yes 2XIN		,,	Specify		: + o
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OUTOUNE	hin 72 8. an "na Medi	Completed	(Specify only highest gra	de completed)  College (1-4or 5	5+)	(Give I	rind of work dor O NOT use reti	ne during most of wo ired)	rking	Court		,
ار 2	TO 100 100 100	Com	12			Secr	etary					ltimore
bu	be filed tal Hygie d othar evant, L	To Be	17. Father's Name (First, Middle, Last) Michael Koryck						me (First, Middle,	Maiden Suman	10)	
hear Maryland	2 should be and Mental is marked of aumatic ever	To	19a. Informant's Name/Relationship (7			10b Mailie	Addross (Stro	Rose C		City of Town	State Tie Co.	of a l
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ASCER More,	s 1 and 2 f Health itam 27 l		20a. Method of Disposition		20b. Pla	ice of Dispos	ition (Name of atory or other p	lice Road	Balti Date	20c. Location -	City or Town,	State
-3 ASCER	Page nent o int: If iry or		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		St.		nislau	s 12/6	/2004	Baltimo	ore, M	1d.
H3 Balti	permit. Pages Department of important: If it, any injury or o		21. Signature of Funeral Service Licen	S00				ndalk Av				
\	2020		23a. Part1. Enter the disease, or comp	plications that caused	the death							proximate
	Dharistan		shock, or heart failure. List only	one cause on each lin	ne.	-				1031,	Inte	erval Between set and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as			(NO) EA	the car	ncer		40	ears
	Examiner		Sequentially list conditions	b								
6	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):						
	s be executed sician and burial-transit	Exan	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):			<u> </u>			
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89	artifica ing ph e as th	Medi	IF FEMALE:									
Box 68	leath certificate t attending physic I for use as the t	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal o	death 3 🗌	Ectopic pregnar Other (specify)	псу		23d. Dat Mo	te of delivery Inth Day	/ Year
o.	that the de ed by the delached	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	time or dea	101 5	Other (specify)					
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ord	v requires been sign should be	ted							1 🗆 Y	res 2 □ No	3 Probably	4 Dunknown
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Sio	endir eath. or: Af the fur	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				M 1	Yes 2 No				
Division of Vital Records, P.O.	s after d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At hom c. <i>(Specify)</i>	10, farm, stre	et, factory, offic	e	28f. Location (S City or Tox	Street and Numb vn, State)	ar or Rural Ro	ute Number,
	To the Hospital or Attending Phyaiclan: The law requires that the death certificate be executed within 24 hours after death.  To tha Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	f examinatio	ledge, death on and/or inv	occurred at the estigation, in my	time, date and place y opinion, death occu	, and due to the durred at the time,	cause(s) and ma date and place, a	nner as stated and due to the	cause(s)
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	1.		May Car	Min	~		ID.	20 0 5	>	Decem	6023	coay
	Y		30. Namé and address of person who	completed cause of d	eath (Item 2	23а) (Туре, Р	rint)			N. Char		reet
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ire &	Spa	eks/	Towson	n, Mdx.2	:1204	

DERRICK E.JETER 04-07824 RKD

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year Physician DECEMBER 4,2004 DERRICK E. JETER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHOCK TRAUMA CENTER N/ABALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 ☐ F Director Yrs. 7-2-1973 NORTH CAROLINA 220-04-3039 31 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-1 show the Medical Examinar must be notified at ANNE ARUNDEL MD. ODENTON 1 X Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 527 REALM CT. EAST USA 21113 death 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Iter any injury or other traumatic evant, the Medical Evantman 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☒ No BLACK þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-TRUCK DRIVER PGT TRUCKING 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LEONARD JETER DORIS JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRJAM JETER(WIFE) 527 REALM CT. EAST ODENTON, MARYLAND 21113 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 ☐ Donation Other (Specify) METRO CREMATORY 12-10-2004 BALTIMORE, MARYLAND 21. Signature of F new | Service Licensee LARRY REESE 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MARYLAND 21401 23a. Park Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (vist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTURIES Physician HRUTTPLE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (biseass or injury that initiated events Due to (or as a consequence of) signed by the attending physician and doe detached for use as the burial-transit The faw requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s autopsy performed? 2 No 1 XXX es 2 No or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) XXYes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 □ No 28a. Date of Injury (Month, Pay Year) 1214104 funeral 28c. Injury at Work? 28d. Describe how injury occurred OFERATOR OF NOTO REYCLE 27. Manner of Death 28b. Time of After Injury 1 Natural 5 Pending 4:46 PM death. investigation 1 Yes 2 No 2 Accident INVOLUED IN COLLISION Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide REALM COURTEAST NEAR RANGOHOT Hospital within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. DECEMBER 5,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 111 PENN STREET BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2004 Registrar

ORIGINAL

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			For State	State of Maryland /	Department of Health		ital Hygier	ne O O O I	
			- State Registrar		Certificate of Death	7	Reg. I	KUU4	38793
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Marylan f show		ō	Mass (Can d) 10b. County	10c. City, Tov	un or Location				10d. Inside City Limits 1 Yes 2 □ No
vith the		Funeral Director	Nary and 106. Street and Number	th 1+	10f. Zip Code	7	10g. (	Citizen of What Cou	intry?
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any injury or other treumstic event. It whetlose Example and item 25 in the profiled at any injury or other treumstic event. It whetlose Example 200 or 28e-f show		2	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No Specify		, •,	Specify: R	ack
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d withir giene.		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	COOK			Priva	ite
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2 should and Mer Is marke		-	19a. Informant's Name/Relationship (T)	190, Print) (daughter) 19	b. Mailing Address (Street and Numb	oer or Rural Ro	oute Number, City	y or Town, State, Zi	p Code)
re, Mc s 1 and 2 s f Health a item 27 is		-	IVIS, VVanda 20a. Method of Disposition	comot	of Disposition (Name of ery, crematory or other place)	Date	Dalte 200.	Location - City or T	own, State
permit. Pages Department of Important: If its			1 ★ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	St. Lu	Ke Church Cem.	12/4/2	1004 P	lum Po	int, Va.
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urs after			4   Homiciae	building, etc. (Specify)			City or Town, Sta	·	
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		edical			ge, death occurred at the time, date at nd/or investigation, in my opinion, dea				
To the To the To the		Σ	29b. Signature and title of certifier	Tripludier	29c. License number D 3066	1	29d. [	Date signed (Month,	Day, Year) 2004
LAN			29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name, and address of person who of the certified (Month, Day, Year)  DEC 0 8 2004	ompleted cause of death (Item 23a)	(Type, Print)	Hd-	212	39.	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Asc. Val		V -1 -		
Reg	istra	ır	DEC 0 8 2004	A STATE OF THE STA	popular				

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 185 Age of Mary and Anend Item 185 Age of Mary and Amend Item 185 Age of Mary and For A State Registrar Certificate of Death Reg. No. &20a-c 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 200 1850 Baby Girl NOU /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Nov 26, 20 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 2004 Director none Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28e-f show other treumatic event, the Mudical Examiner must be notified at MD Montgomery Silver Spring 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 1961 Rosemary Hill Drive 20910 Completed by Funeral <u>USA</u> permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netternoon any injury or other treumating." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Be - Herut Kass ဥ Hirut Kassa 19a. Informant's Name/Relationship (Type, Print) 1961 Rose Mary Hill Drive #R3 Silver Spring MD 2091 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Å Burial 2 □ Cremation 3 Å Removal from State 20c. Location -Addis Ababa. Asmara, Ethiopia Family Cemetery 12-13-04 4 Donation 5 Other (Specify) in state State Anatomy Board 63247 14th St., N. W. Washington, 21201 Baltimore, MĎ art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areas. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** PERINATAL 115 DAY resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit the attending physicien and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by ti 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Npatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1/SNatural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the i 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gler Rd Silven Spring m D Evilo LARD M O MAHLEW 500 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 0 8 2004

			For State Registrar	State of Ma	-	epartm		ealth ar		ental Hygi	_	n I.	32705
			1. Decedent's Name (First, Middle, Last							2. Date of Death Month		Year	3. Time of Death
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	Examin		4a. Fecility Name (If not institution, give	street and number)		4b.	City, Town, or				4c. Count	y of Death	
		•	Carroll County Ho				Westm	inster If Under 24				Carro	
Ì.	Funeral Director		5. Social Security Number 6. Se 15-07-7204  Usual Residence of Decedent	7. Age	88 Y	Mor	nder 1 Year oths Days		Min,	8. Date of Birth (Month, Day, Jan. 12,	<sup>Year)</sup> 1916	9. Birth Cou Mar	place (State or Foreign intry) yland
	and	}	10a. State 10b. County	-	10c. City, Town	or Location	1		·				10d. Inside City Limits
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9	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do chher than "natural", or items 23a or 28a-f ahow avent, I'm Medical Evan in a must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐XN If Yes, Give	lo		es 21XNo			,,		<sub>fy:</sub> Wh	
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o O	deat	sicia	in the past 12 months? 1 □ Yes 2 ☑ No	4 Pregnant at			er (specify)				M	onth	Day Year
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5	sicia s certi lirecto	o Be	examiner?	Hospital: 1 Inpatie	nt 2□ER/Out	nationt 3	T DOA Cthe	r:		(Check only one e 5 ☐ Resider		her (Sneci	6.1
o t	g Phy er thi	n: T	27. Manner of Death	28a. Date of Injui	v 28b. Ti		28c. Injury Work	at		8d. Describe how			
jo	anding Frath.	atio	1 Natural 5 Pending 2 Accident investigation	(World, Da)	7007	M		es 2 □No	0				
Division	or Attand after death Diractor: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, fan c. (Specify)	n, street, fa	actory, office		28	Bf. Location (Street) City or Town,	eet and Num State)	ber or Run	al Route Number,
	pital o		Constitution of	-1-1	-				1				
	To the Hospital or Attending Physicien: within 24 hours alter death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and	or investiga	ation, in my op	e, date and inion, death	piace, ar occurred	d at the time, da	use(s) and m te and place,	anner as s and due t	stated. o the cause(s)
	ro the vithin ro the complex	Me	29b. Signature and title of certifier	`^ -			29c. License	number	_	29	d. Date signe		
)	- > - 0		Dobum 6	Iellom,	ND		D-0	0561	21		12/	5/0	4
	3	-	30. Name and eddress of person who co	ompleted cause of d	eath (Item 23a) (1	ype, Print)							-0 1
	118.1			OSAIMA		RROU	- 1505/	ITA L	u	INTER	, WE	5 mi	NOTER MA
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 8 20		ar's Signature								
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		•	For State (	of Maryland / Depa <i>Cei</i>	artment of Health rtificate of Deat		ital Hygie Reg.	C 0 0 7	38796
	Dharini		Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
·	Physicia /Medic		RUTH E. KUEHNE				ECEMBER	5, 2004	7:10 P. M
	Examin	er	4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location			4c. County of Death	
			MARYLAND MASONIC HOME  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	COCKEYSVIL		Date of Birth	BALTIMO	
	Funeral Director		2.18-09-12.86  Usual Residence of Decedent	88 Yrs.	Months Days Hour	rs Min. 4	Date of Birth Month, Day, Ye 19/1910	6 MAR	place (State or Foreign ntry) /LAND
	ow ow		10a. State 10b. County	10c. City, Town or Lo	ecation				10d. Inside City Limits
	Man a-f sh	tor	MD BALTIMORE	DUNDALK					1 ☐ Yes 2 🕅 No
	th the	Jirec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
	ath wi	ral	1935 FRAMES ROAD		21222			USA	
	er dei	une	Armed F	cedent Ever in U.S. 13. orces?	Was Decedent of Hispanic f Yes, specify Cuban, Mexi	Origin? (Specify ican, Puerto Rica	Yes or No- n, etc.)	14. Race - Ameri Black, White	
36	I'. or	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, G 3 ※ Widowed 4 ☐ Divorced Year or	2X No live Dates:	1 ☐ Yes 2√☐ No <i>Spec</i>	cify:		Specify: WH]	TE
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show he Mcdical Examiner must be mutified at		15. Decedent's Education	16a. Dece	dent's Usual Occupation	mont of working	161	b. Kind of Business/Ir	ndustry
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7	filed wi Hygien sthar th	Co	1 Year	BOOK	KEEPER			CONTRAC	TORS
and	be fit ntal H od oth	Be	17. Father's Name (First, Middle, Last)  JAMES M. OWINGS			other's Name <i>(Fil</i>		den Sumame)	
2	should be and Mental marked o	2	19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street and Nur	I. ELMA I		ity or Town State Zi	n Code)
Σ	42 1 2 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		, , , ,		FRAMES ROAD			21222	
re,	s 1 and 3 f Health itam 27 othar tr		20a. Method of Disposition	20b. Place of Dispo		Date		c. Location - City or T	own, State
Baltimore, Maryland	permit. Pages 1 and Department of Heall Important: If itam 2 any injury or other other		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 1 ☐ Dona/tion 5 ☐ Other (Specify)	LOUDON P	ARK CEM.	12/10/2		ALTIMORE,	
Bal	Deparenti Deparenti Impor any ir		21. Sign tul of Funeral Service Licensee	8	2. Name and Address of Fa	EN BLVD	TOWS		IOME, P.A. 1286
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not ent	er the mode of dying, such	as cardiac or res	spiratory arrest,		Approximate Interval Between
1	Physician	ř	Immediate Cause (Final disease or condition	A Derscherte	i Vosculen	- Differ	ese		Onset and Death
	/Medical Examiner			(or as a consequence of):					
		<u>د</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a nunsequence of):					
(-	ited Insit	Examiner	Cause (Disease or injury	( 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
` ~	execu n and ial-tra	Exal	that initiated events c. resulting in death) Last Due to	(or as a consequence of):					
68760,	ficate be executed physicien and is the burial-transit	edical	d						
_	± 00 €		IF FEMALE:						
Вох	eath certif attending for use a	ian/I	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of deliv	ery Day Year
<u>.</u>	Attending Physician: The law requires that the death cert or death.  actor: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use it	Completed by Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unk		Other (specify)				
P.O.	that the	/ Ph	Part II. Other significant conditions contributing to			art I.	23e. Did tobac	co use contribute to	he cause of death?
ds	luires n sign Md be	q p	End Stage Denertia.	Disease.	Ty Dissere		1 🗌 Yes	2 □No 3 □ Pro	bably 4 Unknown
Ö	w rec	lete	Pere Level Varalin	Disease.	,		24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Re	The la te has age 2	шо	7.55				autopsy performed 1 Yes 2 🔀	d?   death?	ompletion of cause of
ta	ian: rtifica	BeC	25. Was case referred to medical examiner?		26. PI	lace of Death (Cf			
Ž	hysic his ce I dire	10	1 ☐ Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatier				e 6 □Other (Speci	fy)
D C	ing P	on:	1 Matural 5 ☐ Pending (Mo	of Injury 28b. Time o nth, Day Year) Injury	Work?	_	Describe how	injury occurred	
Sic	ttend death ttor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	ee of Injury - At home, farm, sti	M 1 Yes 2		Location /Stree	it and Number or Rur	al Route Number
Division of Vital Records,	or A after Dirac in by	Certification:	4 Homicide determined buil	ding, etc. (Specify)	eet, factory, diffice		City or Town, S		ar riodio ridinsor,
_	To tha Hospital or Attanding Physician: The law requires that the death cerwithin 24 hours after death.  To tha Funeral Diractor: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To tl 2 Medical Examiner: On the and ma	basis of examination and/or in	n occurred at the time, date vestigation, in my opinion, o	e and place, and death occurred a	due to the caus t the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
	o tha ithin 2 o tha omple	Med		nner stated.	29c. License numbe	er	29d.	Date signed (Month,	Day, Year)
	F ₹ F ŏ		R.T. Lilentin	62	Dans	64		12-6-0	Y
	10		30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print)	σγ			· ·
	U		ROBERT LIBERTO, MI	). 5108 B	nr ST	Palto	, she	12177	ľ
	Sta Registi		31. Date filed (Month, Day, Year) 32. DEC 0 8 2004	Use of death (Item 23a) (Type.  FICH B:  Registrar's Signature	Coule				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 38797 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 5, 2004 Ida С. Kenney 6:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oak Crest Care Center Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2)(1)(= Director 216-32-9226 90 March 31, 1914 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23a or 28e-f show the Medical Examinational be notified at 10d, Inside City Limits Director 1 Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces?
 □ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: 3XXWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Candy Store Pages 1 and 2 should be filed v thrent of Health and Mental Hygie rant: If item 27 Is marked other t ijury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Boleslaw Cwalina Golanska Tekla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Cwalina Brother 700 Thornwood Court Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Holy Cross Polish Nat Church Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Donation 5 Other (Specify) 12-9-2004 Baltimore, Maryland f Fungral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on lone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** gangre ne /Medical Due to (or as a consequence of): Examiner vascular Disease peripheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Diabetus been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□No 1 ☐ Yes 2 NO To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - Moon D5864 December 6,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wa Parkville MD 31234 3900 monia 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 0 8 2004 Registrar

		For State Registrar	State of Mary		partment of He ertificate of D		,	giene 004	38798
Physicia /Medic		Decedent's Name (First, Middle, L     ANNA MARY F	,				Decem	Day Year	3. Time of Death 4 12:15 PM
Examine Funeral Director		5. Social Security Number 6. 197–10–0324	race Hospi	yrs. last birthday		If Under 24 Hrs.	3. Date of Birth (Month, Day 7/24/19	4c. County of Deat  R 0 + V  9. Birt. Co	
aryland ahow		Usual Residence of Decedent  10a. State 10b. County		c. City, Town or I					10d. Inside City Limits
death with the Maryland ms 23a or 28a-f ahow rmst be notified at	Director	MD Baltin	nore	Bal	timore				1 ☐ Yes 2 🛣 No
h with t	ai Dir	7810 Riverdale	Avenue		10f. Zip Code 2123	7		10g. Citizen of What Co USA	untry?
e E E	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	in U.S. 13	. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2X No	panic Origin? (Spec , Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		
A N.N.G.  Id 21215-0  illed within 72 ho Illygiene. other than "natur	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	(Giv life.	edent's Usual Occupative kind of work done du DO NOT use retired)  Omemaker	tion tring most of working	3	16b. Kind of Business/	
Maryland 21215-0036 at 2 should be filed within 72 hours alt the and Mental Hygiene. It americal other than "natural", or traumetic event. It is Medical Event.	To Be Co	17. Father's Name (First, Middle, Las Richard W. Hen				18. Mother's Name Katherin		Maiden Sumame)	
ore, Maryle os 1 and 2 should of Health and Mer filam 27 la marke rother traumettic		19a. Informant's Name/Relationship  Joan Lee Chadman			iling Address <i>(Street ar</i> <b>Uxbridge Roa</b> d			r, City or Town, State, 2 and 21234	lip Code)
Ore, pos 1 ar of Heam or Hi itam;		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3	20		position (Name of ematory or other place			20c. Location - City or	
Baltimore, sernit. Pages 1 a Department of Hee mportant: If item any injury or othe page.		*4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	eify)		o Cemetery 22. Name and Address		2004	Delta, Pe	nnsylvania
Balt permit. Depart Import any inj		Seffen	P. Level	else H	arkins Funera	al Home, Inc.		St., Delta,	PA 17314
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ecords, P.O. Box 687 law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
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na Hospit n 24 hour ne Funara	Medical (	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Ex-	Physician: To the best of my aminer: On the basis of exa and manner stated.	knowledge, dea mination and/or i	ath occurred at the time investigation, in my opi	o, date and place, ar nion, death occurred	d due to the o	ause(s) and manner as late and place, and due	stated. to the cause(s)
To th withir To th comp	Ň	29b. Signature and title of certifier	facile.		29c. License		00 2	12/4/	
45		30. Name and address of person wh	o completed cause of death	700		7			UD 11737
Stat Registra		31. Date filed (Morkly, Dy, 80ar)	32 Registrar's S		Sporks	ware Dr	ive, t	CITIMO!	I W. alast

			For	State of Maryland				ental Hy	giene	^ ~ ·
	1000	_	For State Registrar		Cer	tificate of	Death	2. Date of Dea	Reg. No. ZUUL	38799
	Physici		1. Decedent's Name (First, Middle, Last)  Honry E		Leas	sure		Month  Decem	Day Year	3. Time of Death  3. 4 53 A M
}	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	Con	Als. City, Town, o	r Location of Death		4c. County of Dea	th
				ayview Medi	601		nore City	/	n/a	
3	Funeral Director		5. Social Security Number 6. Sex 218-42-0899	7. Age (In yrs. In 60	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 15	y, Year) 0, 1944 Pet	thplace (State or Foreign ountry) nnsylvania
	pu .		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	cation				10d. Inside City Limits
	Maryla e-f eho	tor	Md. n/a			imore				Yes 2 No
	or 28e	Direc	10e. Street and Number			10f. Zip Code	2.201		10g. Citizen of What C	ountry?
	ath w	rail	617 Rappolla St		2 122		21224	-it. Vee es Ne	USA - 14. Race - Am	oriona Indian
36	9 within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28e-f ehow the Maxical Examine must be notified a	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ul> <li>12. Was Decedent Ever in U. Armed Forces?</li> <li>1 ∑Yes 2 ☐ No If Yes, Give Year or Dates V 1 € † T.</li> </ul>		Yes, specify Cubi	dispanic Origin? (Spe an, Mexican, Puerto I Specity:	Rican, etc.)	Black, Whi	te, etc.
9	2 hour		15. Decedent's Edu	cation	16a Decec	lent's Usual Occup	pation		16b. Kind of Business	Vindustry
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land	id be fil lental H ked otl ic even	То Ве	17. Father's Name (First, Middle, Last)  Lawrence Leasu	ıre			Stella			
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg Item 27 Is marked othe other treumatic event,		19a. Informant's Name/Relationship (Ty, Betty Leasure (		19b. Mailin	g Address (Street	and Number or Rura a Street	Balti	er, City or Town, State, more, Md	Zip Code) 21224
	1 and Health em 27		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		ate	20c. Location - City or	
ομ	9 5 = 9		1 ☑Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other pla sary Cer		/2004	Baltimore	e, Md.
Baltimore,	permit. Pa Departmen Important any injury		21. Signature of Funeral Service License	98 A/\					i Funera. Iltimore,	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	n. Do not ent	er the mode of dyi	ng, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between Onset and Death
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tal	icien: Th certificate rector, pag	0	25. Was case referred to medical	71011 39 60	2etcs	114101	26. Place of Death	1 ☐ Yes	7	20110
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Division	for Attendi after death. Director: A	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, str		Yes 2 No	28f. Location (	Street and Number or F	Rural Route Number,
Di<	afor A after Direct of in by	Certification:	4 Homicide determined	building, etc. (Specifi		oot, ractory, conso		City or To	wn, State)	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Phy (Check only one) Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death	n occurred at the ti vestigation, in my	ime, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	within To th comp	₹ e	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
			1 W13 CC	no		120	4383		12/02	04
	271		30. Name and address of persen who co		n 23a) (Type,	Print)	1	- / > 0	12/02/	SOIT, MD
	ر د	ate	31. Date filed (Month, Day, Year)	h Tiv de. Registrar's Signa	iture /	1 100	May Sa	V. W.S	circ le	アルンケー
	Regist		DEC 082	.004 Denies	1	apou	are V			

			For State Registrer	State of	Maryland / [		artment rtificate			nd M		gier Reg. N	4004	388	00
	D1		1. Decedent's Name (First, Middle,	Last)							2. Date of De	Г	ay Year	3. Time of	
	Physicia /Medic		CATHERINE	M. LUS	SK						DEC.	$4,\bar{2}$	2004	2:55	рм
1	Examin		4a. Facility Name (If not institution,		ber)		4b. City, To			f Death		4	c. County of Dea	ith .	
			2702 MEDE CO			46.1.3	FAL If Under 1			24 Ыго			HARFOR		
п	Funeral		5. Social Security Number 216-24-9551	3. Sex 7 1 ☐ M 2 ☐ <b>X</b> F	'. Age (In yrs. last bii 75	πησαγ) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da	iv. Yea	ir) C	thplace (State ountry)	
	Director		Usual Residence of Decedent								DEC.	10,	1920 M	ARYLAN	ע
	yland		10a. State 10b. County		10c. City, Tow	n or Lo	ocation							10d. Inside C	ity Limits
	Mar e-f st	io	MD. HAR	FORD	FA	4LL	STON							1 🗆 Yes	2 🔀 No
	or 28	Director	10e. Street and Number		- 4		10f. Zip C	Code	_			10g. (	Citizen of What C	ountry?	
	th wi	al	2702 MEDE CO	URT			2	104	17				U.S.A.		
	r dea	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S.	13.	Was Deceder	nt of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi		
36	or It	by Fu	1 Never Married 2 Marrie	d 1 ☐ Yes If Yes, Give	<sup>2</sup> X <sup>™</sup> No		1 ☐ Yes 20		Specify:				Specify:		
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show cdical Examiner must be notified at		3 ₩idowed 4 Divorced	Year or Da		Door	dent's Usual	Ossuma	tion			165	Kind of Business	HITE	
5	- 3	lete	15. Decedent's (Specify only highest	grade completed)		(Give	kind of work DO NOT use	done di	uring most	of worki	ing	TOD.	Killa of Busiliess	vindustry	
12	within iene.	Completed	Elementary/Secondary (0-12) 7	College (1-	4or 5+)		AITRE					R	ESTAUR	ANT	
ď	e filec II Hyg othe /ent,	a l	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle	Maide	en Sumame)		
<u>la</u> r	uld be Aenta rked tic ev	To B	GEORGE SIMP	SON					ANNA	A MA	RIE A	MHR	EIN		
Maryland	s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than other traumatic event, I'm M	17 Å	19a. Informant's Name/Relationsh										or Town, State,		
	and 2 ealth n 27 ner tr		CATHERINE R.	LITTLE/D					COUF						
ore		11	20a. Method of Disposition  1XX Burial 2 ☐ Cremation	3 □Removal from S	iaie i	ry, cre	matory or oth	er place			Date	20c.	Location - City or	Town, State	
Ë	Pages ment of I tent: If its		`4 ☐ Donation 5 ☐ Other (Sp	ecify)	HOLL	100	ILL C		-				LTIMOR		LAND
Baltimore,	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service L	censee	11	≥ L	$\overset{\scriptscriptstyle 2.\mathrm{Name}}{\mathrm{LLY}}$	Addres:	s of Facility EILE	žR I	NC. FU	JNE	RAL HO	ME	
_	TD 2 8 0		23a. Part1. Enter the disease, or o	amplications that on	wood the death. Do	1	00 S.	CC	NKLI	NG	STREET	Г,В	ALTIMO	RE, MD.	
	Physician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	or as a consequence	u	la	d	lse			-	>0	Interval Bet Onset and	
Н	Examiner		Sur quetially list conditions	b											
-	D #	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequence	of):									
	ecute and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (c	or as a consequence	of):									
8760,	cate be executed oblysician and the burial-transit	<u>e</u>	,	Due 10 (C	n as a consequence	01).									
87	physics the last	edical		d											
9 X	leath certific attending p i for use as i	/Me	IF FEMALE:	23c. If yes, outo	ome of pregnancy							10	23d. Date of de	livery	
Вох	death certific e attending p id for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal death ant at time of death		Ectopic pred Other (spec						Month	,	Year
P.O.	that the deed by the	nys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	wn										
	res that igned b	by P	Part II. Other significant condition	s contributing to de	ath but not resulting i	n the u	nderlying cau	use give	n in Part I.		23e. Did t	obacco	o use contribute t	o the cause of c	leath?
of Vital Records,	- S	edt	Cerdenva	cular	_ Clise	a	12_				1 🗆 '	Yes	3 □ P	robably 4 🗆	Jnknown
သို့	e law requ has been je 2 shoul	plet									24a. Was		24b. Were a	utopsy findings completion of c	available
ž		Completed	_								perfo	rmad?	death?	s 2□ No	au36 01
ita	ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	one)	<del></del>		
<u>&gt;</u>	S 5 1	일	1 ☐ Yes 2 No	Hospital: 1 ☐ In	patient 2 ER/O			Othe	r: 4□ Nu	rsing Ho	me TE esi	dence	6 ☐Other (Spe	ecify)	
ū	ding P. After t funera	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date o (Month		Time o Injury		c. Injury Work	?		28d. Describe	how in	jury occurred		
sio	Attending r death. sctor: Afte	cat	2 Accident investigation inves	ot be			М		′es 2 □ l		00/ 11 /	<b>21</b> 1			
Division	l or Attendatter deatl Director:	Certification:	4 Homicide determin	and 286. Place	of Injury - At home, fa g, etc. (Specify)	arm, st	eet, factory,	office			28f. Location (3 City or To	street wn, Sta	and Number or R ite)	urai Houte Num	ber,
T	spital ours s serel (		29a. Certifier 12 Certifying	Physicien: To the	best of my knowledge	e, deat	h occurred at	the tim	e. date an	d place	and due to the	cause	(s) and manner a	s stated	
	To the Hospital or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one) Medicel E	xeminer: On the ba	s\s of examination ar	nd/or in	vestigation, in	n my op	inion, deat	th occurr	ed at the time,	date a	nd place, and du	e to the cause(s	;)
	To th within To th compl	Me	29b. Signature and title of certifier	11)/	/		29c.	License	number		7	29d. E	Date signed (Mon	th, Day, Year)	
	A		John of	her			D	18.	33	9	1	eca.	mber	620	360
	1		30. Name and address of person	no completed cause	of death (Item 23a)	(Туре,	Print)	0	1	()	Q.O.A		MA		
			31. Date filed (Month, Day, Year)	ELCICO	egistrar's Signature	7	Mee	X_	VR.	X	THE	<i>r</i> -	1102	1015	
	Sta Registr		NEC 0 8 20	Ø.		Sec.	de la								

			For State Registrar	State of M	aryland / Depa	artment of H rtificate of L	ealth and M Death		ene2004	38801
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	/Medi		JAMES E. LECOMP					DECEMBE	R <sup>D</sup> 3, 2004	
	Examir	ner	4a. Facility Nam <i>e (If not institution, give</i> 1745 JOAN AVE			PARKVII			4c. County of De BALTIMOR	
l	Funeral Director		212-40-2339	x 7. A	ge (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) (	irthplace (State or Foreign Country) RYLAND
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary I sh	į	MD BALTIMON	RE .	PARKVIL	LE				1 ☐ Yes 2 ☐ No
	or 28s	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (	Country?
	23a c	ai	1745 JOAN AVENUE			21234			USA	
036	be filed within 72 hours after death with the Maryland that Hygliene.  Ed other than "natural", or Itams 23e or 28e-f show event, I're Medical Exartirer must be neithed at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ∑ Yes 2 ☐ If Yes, Give Year or Dates:	No No	Was Decedent of Hi 1 Yes, specify Cuba 1 □ Yes 2X No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify:	
2-0	72 ho	etec	15. Decedent's Edi (Specify only highest grad	cation e completed)	16a. Deced	ient's Usual Occupa	ution	ina 1	6b. Kind of Busines	
21215-0036	C * 104	Completed	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or	5+) life. I	OO NOT use retired,	) = -	1	PHONE CO.	
Maryland	should be filed within and Mental Hygiene. s marked other than umatic evant, If E.M.	To Be	17. Father's Name (First, Middle, Last)  JAMES E. LECOMPTE	SR.			ALICE G	• (First, Middle, M • WISEMAI		
Mar	id 2 sho Ith and 27 is ma traum		19a. Informant's Name/Relationship (T		180000				City or Town, State,	Zip Code)
Baltimore, I	Hea Hea am		JAMES E. LECOMPTE  20a. Method of Disposition  1 Burial 2X Cremation 3 D		20b. Place of Dispo	GAFNET E sition (Name of natory or other place		Date 2	D 21234 Dc. Location - City o	r Town, State
ti m	Pages tment of I tant: If its jury or o		* 4 ☐ Donation 5 ☐ Other (Specify,		METRO CR	EMATORY,	INC. 12/8	3/2004	CATONSVILI	LE, MD
Ba	permit. Pages Department of Important: ff it any injury or o		21. Signature of Funeral Service Licens	99		. Name and Addres 521 LOCH				HOME, P.A.
	2	-	23a Pantl. Fator the disease, or comp shock, or heart failure. List only o	ications that cause	d the death. Do not ente				•	Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hiper-	a consequence of):	ardiovas	culas D	isease	,	Onset and Death
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as	a consequence of):					
68760,	icate be executed physician and s the burial-transit	sai Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
		ledicai								
.O. Box	law requires that the death certifics as been signed by the attending pt 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death b	out not resulting in the ur	derlying cause give	n in Part I.			o the cause of death?
<u> </u>	The ate h page	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
/ita	iician: Tł certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of	Phys this al dir	L.	1 ∆ Yes 2 No	lospital: 1 ☐ Inpatie			4   Nursing Hor	me 5 Residen		ecify) SCENE
Division	Attending r death. actor: After by the funer	ertification;	Natural 5 Pending investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	28c. Injury Work' M 1 □ Y	at ? es 2 □No	28d. Describ <i>e</i> how	injury occurred	
É	tal or Atten s after deat al Diractor; ed in by the	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funaral Director completely filled in b	dicai	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best ner: On the basis o and manner st	of my knowledge, death f examination and/or inv ated.	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	and due to the cau ed at the time, date	se(s) and manner a and place, and du	s stated. a to the cause(s)
) .	To the within 2 To the Complet	Me	29b. Signature and title of certifier  Aral Ha	llaun	id_	29c. License	number M E	DE	Date signed (MoniceCEMBER,	th, Day, Year) 5, 2004
14)			30. Name and address of person who co	Meleted cause of c	leath (Item) 23a) (Type, F	Print) 111 PE	NN STREET	Γ, BALTIN	ORE, MARY	ZLAND, 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	hout 1				

	1	For Stete Registrar		d / Department of Health and Certificate of Death	Reg	ene <u>. No 2004 3880</u>
Physician /Medical Examiner		a. Facility Name (If not institution, gr	LOFTUS ive street and number) EMARKETURE	Ab. City, Town, or Location of De.		Day Year 1. 2004 11. 40 At 4c. County of Death
Funeral Director	2	. Social Security Number 6. 298–24–0010	Sex 7. Age (In yrs. 1X) M 2 ☐ F 74	Ast birthday  If Under 1 Year		
oreall will the maryland ones 23e or 28e-f show if must be notified at neral Director	11	0a. State 10b. County  Maryland Anne Ar  0e. Street and Number		y, Town or Location  Fdgewater  10f. Zip Code	100	10d. Inside City Limi 1 ☐ Yes 2 ☐  3. Citizen of What Country?
E and	1	342 Colony Point  1. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 □ No If Yes. Give	1 ☐ Yes 2 ☑ No Specify:		USA  14. Race - American Indian, Black, White, etc.  Specify: White
al Hygiene. I other then "neturel", of yent. the Medical Example.  Se Completed by		15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	Year or Dates: 1952- Education rade completed)  College (1-4or 5+)  4 years	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)  Railroad Executive	vorking 16	Sb. Kind of Business/Industry  Railroad
Mental Hygi Merked other latic event.	1	7. Father's Name ( <i>First, Middl</i> e, <i>Las</i> Patrick		L	ame (First, Middle, Ma Helen Nooi	aiden Sumame)
tof Health and I fish 27 Is m		Marie S. Loftus/  Oa. Method of Disposition  1 X Burial 2 □ Cremation 3	Wife 20b. P	19b. Mailing Address (Street and Number or II  342 Colony Point Pl  Place of Disposition (Name of International Colonia Place)	., Edgewate	er, MD 21037 Oc. Location - City or Town, State
Definit. Fages 1 at Department of Hes Important: If itsm eny injury or othe one.	2	*4 Donation 5 Other (Special Signature of Funeral Septice Life	77	22. Name and Address of Facility (2973 Solomons Isla	George P. 1	Davidsonville, MD Kalas Funeral Home
validation and solution and sol	III CO	23a. Part1. Enter the disease, or cor shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last		n. Do not enter the mode of dying, such as cardinal hummsthage Zuence of):  Catic Caruca.	ac or respiratory arres	Approximate Interval Batween Onset and Death 26 day.  I year
d the state of	10		d.	uence of):		
by the attending physiched for use as the ast head for use as the attended for use as the attended for use as the attended for use as the attended for use as the attended for use at the attended for	11 2	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d.  23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	ancy I death 3 ⊟Ectopic pregnancy		23d. Date of delivery Month Day Year
d by the attending physicached for use as the Physician/MedI	P	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  ACULE PLAA	d.  23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of deglicontributing to death but not result Falluce	ancy I death 3 ⊟Ectopic pregnancy	23e. Did toba 1 □ Yes	Month Day Year
ate has been sign page 2 should be		23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  ACVLE PLAA  Abdominal	d.  23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of deglicontributing to death but not result Falluce	ancy I death 3 □Ectopic pregnancy eath 5 □ Other (specify)		Month Day Year  cco use contribute to the cause of death?  2 No 3 Probably 4 Unknow  24b. Were autopsy findings availat prior to completion of cause of
is certificate has been sign director, page 2 should be To Be Completed by		23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  ACULE PLAA	d.  23c. If yes, outcome of pregnal   Live birth   2   Feta   4   Pregnant at time of dependent of the second of t	ancy I death 3 Dectopic pregnancy eath 5 Other (specify)  utting in the underlying cause given in Part I.  26. Place of D  ER/Outpatient 3 DOA  28b. Time of Injury M 1 Yes 2 No  ome, farm, street, factory, office	24a. Was an autopsy performs 1  Yes 2 eath (Check only one)  Home 5 Resident 28d. Describe how	Month Day Year  cco use contribute to the cause of death?  2 No 3 Probably 4 Unknot  24b. Were autopsy findings availal prior to completion of cause of death?  No 1 Yes 2 No  ce 6 Other (Specify)  injury occurred
is certificate has been sign director, page 2 should be To Be Completed by	2	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions  A b d om in a conditions  A b d om in a conditions  25. Was case referred to medical examiner?  1   Yes 2   No conditions  27. Manner of Death  1   Natural 2   Accident 3   Suicide 4   Homicide   Could not determine  29a. Certifier 1   Certifying F	d.  23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  contributing to death but not result fall Use  Sepsis  Hospital: 1 Inpatient 2 Department on be 28e. Place of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifications)	ancy I death 3 Dectopic pregnancy eath 5 Other (specify)  utting in the underlying cause given in Part I.  26. Place of D  ER/Outpatient 3 DOA  28b. Time of Injury M 1 Yes 2 No  ome, farm, street, factory, office	24a. Was an autopsy performs 1  Yes 2 eath (Check only one)  Home 5 Resident 28d. Describe how 28d. Location (Stre City or Town,	Month Day Year  cco use contribute to the cause of death?  2 No 3 Probably 4 Unknow  24b. Were autopsy findings availat prior to completion of cause of death?  1 Yes 2 No  ce 6 Other (Specify)  injury occurred  et and Number or Rural Route Number,  State)  se(s) and manner as stated.
his certificate has been sign at director, page 2 should be To Be Completed by	2	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions  ACVIE PLAA  Abdominal  25. Was case referred to medical examiner?  1   Yes 2   No    27. Manner of Death  1   Natural 5   Pending investigates    2   Accident 3   Suicide 6   Could not determine    22a. Certifier   Check only 2   Medicel Exe	d.  23c. If yes, outcome of pregnal   Live birth   2   Feta   4   Pregnant at time of dependent of the second of t	ancy I death 3 Dectopic pregnancy eath 5 Other (specify)  utting in the underlying cause given in Part I.  26. Place of D  EP/Outpatient 3 DOA  Other: 4 Nursing 28b. Time of Injury M 1 Yes 2 No  ome, farm, street, factory, office  wledge, death occurred at the time, date and plattion and/or investigation, in my opinion, death occurred at the time.	24a. Was an autopsy performs  1 Yes 2  eath (Check only one)  Home 5 Residence  28d. Describe how  28f. Location (Stree City or Town,  ce, and due to the caucurred at the time, date	Month Day Year  cco use contribute to the cause of death?  2 No 3 Probably 4 Unknow  24b. Were autopsy findings availat prior to completion of cause of death?  1 Yes 2 No  ce 6 Other (Specify)  injury occurred  et and Number or Rural Route Number,  State)  se(s) and manner as stated.

		1- For State of Maryland / Department / Department / Depa	artment of Health and M rtificate of Death		ene 004 3	38803
Discontinu		Decedent's Name (First, Middle, Last)		2. Date of Death	1 _	3. Time of Death
Physici /Medio		Margery Ella Leadore		1/00 Cmbs	Day Year 28, 200 4	10:25 AM
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Death	
		Lorien Bel Air  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Bel Air If Under 1 Year   If Under 24 Hrs.		Harford	
Funeral Director		218-81-5338  Usual Residence of Decedent  1 M 2 F 80  Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 11/21/1	rear) Country	
land ow		10a. State 10b. County 10c. City, Town or Lo	cation		10d	I. Inside City Limits
Man,	tor	MD Harford Havre de	e Grace			1 XYes 2 □ No
th the	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country	y?
ath w		1314 Ontario Street	21078		USA	
er de Items	Funeral	Armed Forces?	Nas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Black, White, etc	
036 ors aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: White	
ING 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or items 23a or 28a-f show event. The Medical Examiner must be inclined at	ted	15. Decedent's Education 16a. Decedent	dent's Usual Occupation	11	6b. Kind of Business/Indus	
212 218 6. e. n Med	Completed	(Specify only highest grade completed) (Give life. L	kind of work done during most of workir DO NOT use retired)	ng		,
d 212 filed withi Hygiene. other than	Con	11th Ass	embly Line Worker		Shoe Compa	ny
<b>⊆</b> 9 8 9 5	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame)	
Ore, Marylar ss 1 and 2 should be st 1 earl and Menta fitem 27 Is marked r other treumatic ex	To	Perry C. Nickle	Clara A			
Ma d 2 st th an 7 Is r treur			g Address (Street and Number or Rura			ode)
Te, N 1 and Health tem 27		20a. Method of Disposition 20b. Place of Dispo	Darling Rd., Blac		NIO 43004  Oc. Location - City or Town	State
Pages nent of nnt: If its		1 XBurial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)  Mt. Erin	natory or other place)			
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any injury or other once.			the second secon		avre de Gra	ce, MD
B F F F F F F F F F F F F F F F F F F F		Children Smits 12	tchell-Smith Fune: 3 S. Washington,	ral Home Havre c	e, P.A. Ne Grace Mi	D 21078
		23a. Part1. Enter the disease, or complications that caused the death. Do not enterprise, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arres	st, A	pproximate iterval Between
Pnysician		Immediate Cause (Final disease or condition			0	inset and Death
/Medical		resulting in death)  a  Due to (or as a consequence of):			7)	1ews
Examiner		Sequentially list conditions, b.				
ed issi	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure 2)				
xecul and al-trar	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of);				
cate be executed cate be becuted physician and the burial-transit	dicalE					
	Φ.					
Geath certific	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3□	Ectopic pregnancy		23d. Date of delivery	
b deat he att	sicie	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Da	y Year
that the de detached to	Phy	3 - OUKHOWH				
S tres the igner	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to the c	
	eted		un derende	Yes		
has has	ompleted			24a. Was an autopsy performe	24b. Were autopsy prior to comple	findings available letion of cause of
T ate	e Co	Of Microsoft and American			ed? death? ₹No 1 Yes 2	□ No
90	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death Other: 4 D Nursing Hom		do de	autali.
	H-	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 21	Bd. Describe how		I'm CLIVING
Attending F r death. ector: After by the funer.	ertiflcation;	1 ⊠Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 Tyes 2 No			
r Atte	tiflo	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	Bf. Location (Stree City or Town,	et and Number or Rural Ro	oute Number,
rs aft	Cer	building, sic. (opeony)		Oily of Town,	State/	
To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invalid	occurred at the time, date and place, ar estigation, in my opinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as state e and place, and due to the	d. e cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day	/, Year)
		> Jordan mo	715314	11	ovember 28.	,2004
0		30. Name and address of person who completed cause of death (Item 23a) (Type, F		1	Hospice El	1/5
-5~		11 Farkas, M17 Slasons N 31. Date filed (Month, Day, Year) 22. Registrar's Signature.	orthern Cheso	y calle	Hospice, El	Klan, MD
Stat Registra		31. Date filed (Month, Day, Year) DEC 0 8 2004  32. Registrar's Signature	books			

			1 - For Stata Registrar	State	of Mary		artment of H <i>rtificate of L</i>		nd M		ene 0 0	) 4	38804
	Physic /Medi		1. Decedent's Name (First, Middle	MO-	awsh	c î				2. Date of Death Month Dec. 5,	Day 2004	Year	3. Time of Death 1:40pm M
	Exami		4a. Facility Name (If not institution,		ımber)		4b. City, Town, or	Location of	Death		4c. County	of Death	)
			1871 Old Field				Huntingto	own, Ma				Calve	ert
	Funeral Director		410-535-200	6. Sex 1 M 2 ☐ F	7. Age (In 80	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, ) July 14,	(ear) 1924	9. Birth Cou	pplace (State or Foreign intry) Detroit, MI
	and		Usual Residence of Decedent  10a. State 10b. County		100	. City, Town or Lo	ocation					1	10d. Inside City Limits
	ne Maryl 8a-f sho	ector	MD	Calver				Hunting	gtown	n, MD			1 XYes 2 ☐ No
	th with the	al Dire	10e. Street and Number 1871 Oldfield Da	ive			10f. Zip Code 20639	9		100	g. Citizen of V USA	What Cou	intry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event. In Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Valvidowed 4 Divorced	12. Was Dec Armed F od 1 X Yes If Yes, G Year or D	orces? 2 □ No ve	Unk.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 25500	spanic Origin , Mexican, I Specify:	n? (Spec Puerto P	cify Yes or No- Rican, etc.)	14. Rac Blac Specify	k, White	ican Indian, , etc. nite
5	72 h	etec	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occupa kind of work done di	tion	of workin	16	ib. Kind of Bu	ısiness/îr	ndustry
21215-0036	d within giene. er than "	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	cilled Trade		N WOIKIII	g	Ford	Motor	Company
Maryland	uld be file fental Hyg rkad othe tic evant,	To Be C	17. Father's Name (First, Middle, L Theodore Morawsk							(First, Middle, Ma a Kowalski		16)	
_	nd 2 shoulth and N 27 is ma		19a. Informant's Name/Relationsh Gregory Morawski			19b. Mailir 1871	ng Address (Street ar Oldfield Dr	ive, Hu	or Rural Intin	Route Number, C	ity or Town,	State, Zi,	o Code)
Je,	of Hear		20a. Method of Disposition	~		b. Place of Dispo	-	1	Da		c. Location -		own, State
altimore,	it. Page intment c intant: If injury or		1 Burial 2 Cremation  4 Donation 5 Other (Sp.	ecify)	12	bunt Olive	et Cemetery	Decemb	er 13	3, 2004 E	etroit	MI	
Ba	Depa Impo any is		21. Signatur of runeral Service L	5'			Name and Address Charles L. 1501 Fast	Stevens Fort Av	<i>r</i> e. B	altimore M	D 21230		
	Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a	1000	sequence of):	er the mode of dying	, such as ca	rdiac or	respiratory arrest			Approximate Interval Between Onset and Death
	Examiner	10	Sequentially list conditions,	b		Sequence of).							
	acuted ind transit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
58760,	ficate be executed physician and is the burial-transit	dlcalEx	lesolling in dealin, East	Due to	(or as a con	sequence of):							
_	ntifica ng pł s as tl	a)	IF FEMALE:										
O. Box	at the death certific by the attending p tached for use as it	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		oirth 2 ☐ F ant at time (	etal death 3	Ectopic pregnancy Other (specify)				23d. Date Mon		ery Day Year
S, P	es fha igned be de	by	Part II. Other significant condition	s contributing to de	eath but not	resulting in the un	derlying cause given	in Part I.					ne cause of death?
ecords,	requi	eted							_	1 Yes	2 □ No	3 Prob	ably 4 Unknown
r		Completed								24a. Was an autopsy performed 1 ☐ Yes 2 🖸	12 de	/ere auto rior to cor eath? □ Yes	psy findings available impletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?							Check only one)			
0	this ald	2	1 Yes 2 No			ER/Outpatient	3□ DOA Other	4 🗆 Nursin	ng Home	5 Residence	e 6 □Othe	r (Specify	1)
	ding F h. After funera	lon	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury h, Day Year	28b. Time of Injury	28c. Injury a Work?	lt.	28	d. Describe how i	njury occurre	d	
UIVISION	Attanding or death. actor: After by the fune	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	be on place	-6.1-6	A b (	The second	s 2 No	1				
2	ital or A rs after al Dirac	Certification;	4 Homicide determin	buildi	ng, etc. (Spe	t home, farm, stre	et, factory, office		28	f. Location (Stree City or Town, S	t and Numbe tate)	r or Rura	l Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the aminer: On the ba and mann	1212 OL BYGILL	knowledge, death ination and/or inv	occurred at the time, estigation, in my opin	, date and pl nion, death o	lace, and	d due to the cause at the time, date	e(s) and man and place, ar	ner as st nd due to	ated. the cause(s)
	To t To t	₹[	29b. Signature and title of certifier				29c. License r	number		29d.	Date signed	(Month, I	Day, Year)
_	MI				MD		79	71940	7		121	5/0	4
1	30(,		30. Name and addless of person with	o Month	of death (I	tem 23a) (Type, F	2/10 PC	ince 1	Fred	brick h	no 2	067	5
	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Sig		, ,	(( )	4	1		0-7	
	Registra	ar	DEC 0.8	2004	Bene	was for	Spork	2					

			1- State of Maryland / Depart  Certification  Certification	ment of Health and M ficate of Death		ene 2004	38805
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
1	/Medi		Barbara Mahool		December	7 2004	6:32a M
	Examir	ner	Fairhaven	b. City, Town, or Location of Death Sykesville		4c. County of Deat Carroll	h
	Funeral Director			f Under 1 Year If Under 24 Hrs. Nonths Days Hours Min.	8. Date of Birth (Month, Day, 1) Dec 9 19		nplace (State or Foreign
	Aaryland f show ed et	ō	10a. State 10b. County 10c. City, Town or Location 10d 10d 10d 10d 10d 10d 10d 10d 10d 10d				10d. Inside City Limits 1 1 Yes 2 □ No
	with the Page or 28s-	Director	10e. Street and Number 7200 Third Avenue	10f. Zip Code 21784		g. Citizen of What Co JSA	
36	be filed within 72 hours after death with the Maryland hal hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	y Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes, Give 1	s Decedent of Hispanic Origin? (Spress, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White Specify: Wh	e, etc.
Maryland 21215-0036	n 72 hour: "natural' edical Ex	Completed by	15. Decedent's Education 16a. Decedent (Give kind	t's Usual Occupation d of work done during most of workl NOT use retired)	ing 16	6b. Kind of Business/I	
212	d withi	ф	Elementary/Secondary (0-12) College (1-4or 5+) Homer		1	Domestic	
and	2 should be filed within 72 and Mental Hygiene. is marked other than "nat aumatic event, the Medici	To Be C	17. Father's Name (First, Middle, Last) Dr. John Gardner Murray, Jr.		a Johnson	aiden Sumame)	
	and 2 shou ealth and M n 27 is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or Rura t Street Harriso	al Route Number, (	City or Town, State, Z	ip Code)
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e once.		20a. Method of Disposition  1 ☐ Burial 2 ▼Cramation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cramator	on (Name of	Date 20	oc. Location - City or Tokesville,	
Balt	permit. F Departm Importar any injur		21. Signature of Funeral Service Licensee 22. Na		ight Fune	eral Home	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ne mode of dying, such as cardiac of	or respiratory arres	21/04 t,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)  Due to (or as a consequence of):	Demony			2 111
	ned insit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury				
8/60,	cate be executed obysician and the burial-transif	dical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
O. BOX 6	ne death certifle the attending I thed for use as	by Physiclan/Mec		ropic pregnancy her (specify)		23d. Date of delin	rery Day Year
dS, Γ	Se Be		Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		cco use contribute to	the cause of death?
Records,	> 0 0	Completed	A		24a. Was an autopsy performe	24b. Were aut	opsy findings available ompletion of cause of
-		မ လ	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 ⊡		2□ No
		tlon; To B	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	DOA Other: 4 Nursing Hon	The second secon		fy)
DIVISION	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Certificat	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	he Hospit n 24 hour he Funera	edical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occ and an annual content of the basis of examination and/or investigated.	igation, in my opinion, death occurre	ed at the time, date	and place, and due t	o the cause(s)
ł	Mithi Tot com	Σ	29b. Signature and title of certifier  Park J. Man, M.S.	29c. License number 0 7 2 P 2 2	29d.	Date signed (Month,	Day, Year)
	6		29b. Signature and title of certifier  John J. Manuary  30. Name and address of person who completed cause of death (Item 23a) (Type, Pript  31. Date filed (Month, Day, Year)  PEC. 0 8 2004	1-6 D. R.	eichert.	, KM	21136
	Sta Registr		31. Date filed (Month, Day, Year)  BEC 0 8 2004  32. Registres Signature	oorke			

			1 - For State Registrer	State of Man	yland / Depa			lental Hygie	•	
	Physic /Medi	cal,	1. Decedent's Name (First, Middle, Las	PI	YAZU	R		2. Date of Death Month December	Day Year 5 2004	3. Time or beach 5
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give Anne Arundel Med 5. Social Security Number 216–30–5698	ical Center	r In yrs. last birthday) 70 Yrs.	Annapo  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Feb. 9,	Anne Arun  Anne Birth  Gear)  1934  Mary	
	D	Director	Usual Residence of Decedent  10a. State  10b. County  MD  Anne Aru  10e. Street and Number	10	Oc. City, Town or Lo	ille				10d. Inside City Limits 1 ☐ Yes 2 No
36	d within 72 hours after death with the Maryland gene. vr then "neturel", or Items 23a or 28a-1 show tre Medicel Everiffer must be notified at	by Funeral Dir	708 Oser Drive  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 (TNo If Yes, Give Year or Dates:	1	10f. Zip Code 210 Was Decedent of H If Yes, specify Cuba 1□ Yes 2 XNo	ispanic Origin? (Spe an, Mexican, Puerto Specify:		J. Citizen of What Cou USA  14. Race - Amer Black, White  Specify: W	ican Indian,
121215-0036	d within giene. r than "	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of workii 1)	ng	Own Home	ndustry
Maryland	s 1 and 2 should be filar f Health and Mental Hyg item 27 Is marked othe other traumatic event,	To Be	17. Father's Name (First, Middle, Last)  Joseph Plotczyk  19a. Informant's Name/Relationship (T.					nce I Route Number, C	City or Town, State, Zi	p Code)
Baltimore,	it. Page rtment o rtant; If njury or		Chester Mazur (H  20a. Method of Disposition  1	Removal from State	20b. Place of Dispo cemetery, crer Our Lady	osition (Name of matory or other place of the F	ields 12/	ate 20 8/2004 M	c. Location · City or T Iillersvil	
í	WI S		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	libetions that caused the		12 Ridge	ss of Facility Funeral 1y Avenue g, such as cardiac o	Annapol	is.MD 214	Approximate Interval Between Onset and Death
8760,	/Medical Examiner.	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	onsequence of):	the w	vomo c	y 108	S	5-10 years
P.O. Box 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy			23d. Date of deliv	ery Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Dther significant conditions co	ntributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	1 🗆 Yes		pably 4 Hinknown
Vital Records,	ysician: The lavis certificate has director, page 2	Be Completed	25. Was case referred to medical examiner?				26. Place of Death	and an arrange arrange	prior to co death? 1 ☐ Yes	
Division of \		Certification; To	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	Hospital: 1 □ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	or: 4 □ Nursing Hom or at 2 or at 2 or at 2 or at 2 or at 2 or at 2 or at 2 or at 3 or at 4 o	ne 5 Residenc 8d. Describe how	e 6 Other (Specificinity occurred	5y)
DİVİ	in Line		3 ☐ Suicide 4 ☐ Homicide  29a. Certifier  1 ☐ Certifying Phy	28e. Place of Injury building, etc. (S	Specify)	occurred at the tim	ne date and place a	City or Town, S	p/s) and manner as s	tated
	To the Hospital within 24 hours a To the Funeral t completely filled	Medical	(Check only 2 Medicel Exemination one)  29b. Signature and title of certifier	iner: On the basis of exa and manner stated.	amination and/or inv	estigation, in my op	pinion, death occurre	d at the time, date	and place, and due to	the cause(s)
	ń		30. Name ad ad es of per in who co	ompleted cause of death	(Item 23a) (Type,	Print) Rid	gly A	v An	nApolis	MA
	Sta Registr	4.1	31. Date filed (Month, Day, Year)  DEC 0 8	32. Register's	Signature	9 Spar	Kal			

			Amend item#7,8, perfh, 6838,1 State of Maryland / Dep	nggiphe/MK. Insure All Co	pies Are	e Legible.
			1- State of Maryland / Dep	ertificate of Death	ai mygiei Reg. N	. 00007
	Physici	an	Decedent's Name (First, Middle, Last)		te of Death	3. Time of Death
	/Medic	cal	John Paul Mannion  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ember	5 2004 3:10 A <sup>M</sup>
	Examin	ier	Stella Maris Hospice	Timonium		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	) If Under 1 Year If Under 24 Hrs. 8. Da Months Days Hours Min. (Me	te of Birth onth, Day, Yea	9. Birthplace (State or Foreign
-	Director		215-30-7007   TSUM 2DF 71 61 Yrs. Usual Residence of Decedent	Oct	· 4, 15	Maryland
	hours after death with the Maryland tural; or Items 23a or 28a-f show at Examiner must be rediffed at	_	10a. State 10b. County 10c. City, Town or t	ocation		10d. Inside City Limits
	the Ma	ecto	MD Baltimore Timonium  10e. Street and Number	1017.0	100	1 ☐ Yes 2 🔀 No
	3a or	Funeral Director	37 E. Timonium Road	10f. Zip Code 21 093	USA	Citizen of What Country?
	ems 2	nera		Was Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican,		14. Race - American Indian, Black, White, etc.
36	rs afte	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 Yes 2√ No Specify:	0.0.)	Specify:
Maryland 21215-0036	be filed within 72 hours after death with the Marylan tal Hygiana. tal Hygiana. d other than "natural", or Items 23a or 28a-f show seent, the M. cical Examiner must be rediffed at	ted t	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b.	White Kind of Business/Industry
7	filed within 72 Hygiene. ther then "net int, the Wedic	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)		,
7 0	filed w Hygier Athar tl	CO	12 4 Audi	18. Mother's Name (First,		ate of Maryland
<u>a</u>	should be nd Mental markad o imatic eve	To Be	John P. Mannion		Ruff	on duniame)
کام	2 sho and Is m	_		ing Address (Street and Number or Rural Route		
	1 and Health am 27 thar tr		Maureen E. Mannion / wife 37 E  20a. Method of Disposition 20b. Place of Disp	. Timonium Road; Timor	-	
Baltimore,	Pages nent of int: If it iry or o		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State	amatory or other place)  Lley Mem Gardens 12/7/04		Location - City or Town, State
<u>=</u>	permit. Page Department of Important: If any injury or ottog.			2. Name and Address of Facility		monium, MD O5O York Road
מ	88 58			uck Towson Funeral Hom	ne T	owson, MD 21204
Ц	[		23a. Part1. Enter the disease, or complications the caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final	iter the mode of dying, such as cardiac or respi	ratory arrest,	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)  a. GLIOBLASTOMA  Due to (or as a consequence of):			
	Examiner					
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause Caises or Marry			
ń	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
-	0 3 0	Icai	d			
X DQ	certificat nding phy use as th	hysician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
POS.	death a atten d for u	Iclan	in the past 12 months?  1 Ver 2 No.  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
5	at the	Phys	9 ☐ Unknown 9 ☐ Unknown			
S.	w requires that the disbeen signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	e. Did tobacco	use contribute to the cause of death?  2 \( \sum No \) 3 \( \sup \) Probably 4 \( \sum \)Unknown
cords	as been 2 shout	mpleted		24	a. Was an	24b. Were autopsy findings available
r,	ate has	0			autopsy performed? Yes 27 N	prior to completion of cause of death?
VII a	Physician: The law this certificate has braidirector, page 2 s	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec		
5 8	> .9 0	2	1		Residence	
UNISION	ath. r: Afte	atlor	1 X Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	of 28c. Injury at Work?  M 1 \[ Yes 2 \] No		dry obbarrou
<u> </u>	ter der irecto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		ation (Street a	and Number or Rural Route Number, te)
ב ב	ours at		29a. Certifier 1X Certifying Physicien: To the best of my knowledge, deal	th acquired at the time, data and place, and due	to the count	a\d
-	io the mospina or Attanding Pro- within 24 hours after death.  To the Funaral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	en occurred at the time, date and place, and due investigation, in my opinion, death occurred at the	e time, date ar	s) and manner as stated.  nd place, and due to the cause(s)
	To the comp	Ň	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
_	()	_		D43725		12/6/04
16	7/		30. Name and address of person who completed cause of death (Item 23a) (Type, DR. TARIQ MAHMOOD 2300 DULANEY VA	,	יחחוכ ת	, , ,
	Sta	***	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4	n 7103.	
DI II	Registra	ar	DEC 0 8 2004 Solution 15	Sparke		

				partment of Health and Me ertificate of Death	ental Hygie	NHHP SSSHS
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  WILLIAM	RRIS	2. Date of Death Month	Day Year 5474 M
	Examir		4a. Facility Name (If not institution, give street and number) BON SECOUR HOSPITAL	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
	Funeral Director		5. Social Security Number  217-58-6856  Usual Residence of Decedent  6. Sex 1 M 2 F  7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 2-1-195	9. Birthplace (State or Foreign Country)  WASHINGTON DC
	Maryland I-f show	tor	10a. State         10b. County         10c. City, Town or           MD.         N/A         BALTIM			10d. Inside City Limits 1∑Yes 2 ☐ No
	ier death with the Marylan Items 23e or 28a-f show recimust te notified at	Funeral Director	10e. Street and Number 1658 WARWICK AVE.	10f. Zip Code 21216	10g.	Citizen of What Country?
900	within 72 hours after death with the Maryland ene. than "nature!", or items 23e or 28e-f show the Madical Examirar inust be notified at	þ	11. Marital Status  1 Never Married 2 Married   12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married   1 Yes 2 No   1 Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F  1 Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
Baltimore, Maryland 21215-0036	be filed within 72 hours afte ital Hygiene. Ind other than "naturel", or li event, the Mudical Exame	Completed	(Specify only highest grade completed) (Git Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation we kind of work done during most of workin . DO NOT use retired)  ABORER	ng	CONSTRUCTION
/land		To Be C	17. Father's Name (First, Middle, Last) WILLIAM MORRIS SR.	18. Mother's Name  LOTTIE	(First, Middle, Maid	
, Mary	nd 2 shall and alth and 27 is m			iling Address <i>(Street and Number or Rural</i> 558 WARWICK AVE. BAI		
imore			Burial 2 Transition 3 Demoval from State Cemetery, Ci	position (Name of Date of Position (Name of Position of Other place)  N CEMETERY 12-9-		LTIMORE, MARYLAND
Balt	permit. Page Department of Important: If any injury or once.			雅 Name and Address of Facility PHIL 721-27 N。MONROE ST		
	Pnysician /Medical Examiner	her	23a. Part Inter the disease, or complications that caused the death. Do not eshock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	monory ARRE	r respiratory arrest,	Approximate Interval Batween Onset and Death
x 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Medical Examine	resulting in death) Last  Due to (or as a consequence of):  d	<i>S</i>		
.O. Box	that the death certific ed by the attending p detached for use as	Physician/M		B Ectopic pregnancy Country Other (specify)		23d. Date of delivery  Month Day Year
rds, P	w requires that the been signed by the should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
al Records,	The law ate has b page 2 st	Completed		EDING	24a. Was an autopsy performed 1 Yes 2	
sion of Vital	this al dir	ation: To Be	25. Was case referred to medical examiner?  1	of 28c. Injury at 28		6 ☐Other (Specify) njury occurred
Division	itel or Attors after de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	street, factory, office	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifler (Check only one)  Certifying Physicien: To the best of my knowledge, dea   Medical Exeminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred	d at the time, date a	and place, and due to the cause(s)
j	oc o o	-	29b. Signature and title of certifier These G Hamilton	29c. License number 0829/	29d. [	Date signed (Month, Day, Year) 12-05-2004
	71		30. Name and address of person who completed cause of death (Item 23a) Type  A HAMI TON BON OC	Lour Hospita	2 BA	ESSIS OM OT
	Sta Registr	198	31. Date filed (Month, Pay, Year)  32. Registrar's Signature	Sparks		

4940 EASTERN

**ORIGINAL** 

32. Registrar's Signature

13Alhmore

State Registrar Michael

DEC 0 8 2004

31. Date filed (Month, Day, Year)

LAPE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Yeer 40 **Physician** Ε Dorothy Osbourne 200 P.M /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street and number) Examiner Oak Crest Redwood Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) **Funeral** Month, Bay, Yeer) February 5 1919 Days Yrs 218 03 1551 Baltimore City, MD. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Haaith and Mental Hygiana. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiana.
7 is merked other than "natural", or flams 23a or 28a-f show traumetic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Parkville Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd. Apt. 1116 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White Completed by 3K Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Self Employed Ourtain Seanstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Magdaline David Hutson Hicks Snyder 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David Edward Osbourne 232 Sunny Vale East Montgomery, Texas 77356 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State ò Moreland Memorial Park December 8 2004 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) injury 22. Name and Address of Facility Lassahn Funeral Home Inc 21. Stgnature of Funeral Service Licensee 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediete Cause (Final diseese or condition resulting in death) /Medical Cerebra Examiner Due to (or as a consequence of) by Physician/Medical Examiner arteriosclerotic The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Box 68760, Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? P.0. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Jeffknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Medical Certification: To Be Completed 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate has b completely filled in by the funeral director, paga 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ NO Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŝ 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier menion December MO 5864

State Registrar DHMH 16 Rev 6/95

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Osbourne

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32. Registrar's Signature

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Houth, Pay8 2004

		-	For State Registrar	State o	f Marylan	d / Depa		of H	ealth a	and M		giene Reg. NG		38811
	Physici	an	1. Decedent's Name (First, Minagelo	Pallante							2. Date of Dea Month Dec.	1, Day 20	004 Year	3. Time of Death 4:10p M
	/Medic Examin		4a. Facility Name (If not institu 102 Aqueduct		mber)		4b. City, To			of Death		4c. Co	ounty of Death	-
3	Funeral Director		5. Social Security Number 365–10–4589	6. Sex 1 <b>⊠</b> M 2□ F	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Sept. 3,	, Year) 1910		place (State or Foreign ntry) aly
	/land		Usual Residence of Decedent  10a. State 10b. Cou	nty	10c. City	y, Town or Lo	ocation						1	Od. Inside City Limits
	e Man Ba-f sh atified	Director	MI 1	Vaccarrib					Height	ts				XX Yes 2 □ No
	th with th	ai Dire	10e. Street and Number 14342 Edshire				10f. Zip C		3312			10g. Citize	n of What Cour	ntry?
960	n 72 hours after death with the Maryland "naturel", or Itams 23a or 28a-f show	by Funerai	11. Marital Status  1 Never Married 2 N  3 XWidowed 4 Divorce	Armed For larried 1 ☐ Yes If Yes Gir	2 <b>]∑</b> No ve		Was Decede If Yes, specif	fy Cubar	spanic Origin, Mexican Specify:	i, Puerto	ecify Yes or No- Rican, etc.)		. Race - Americ Black, White, pecify: Whi	etc.
		Completed		lent's Education hest grade completed)  College (	1.40(5+)	(Give	dent's Usual kind of work DO NOT use	done d	luring most	t of worki	ing	16b. Kind	of Business/In	dustry
212	e filed within al Hygiene. I other than " vent, II e M.	Com	8	0			S	uperi	ntende		(Final A 6) defin		tamotive	
Maryland	should be fill and Mental H marked oth	To Be	17. Father's Name (First, Midd Pasquale Pallam						18. Mothe		e (First, Middle, Beth Dem		•	
	nd 2 sho lth and 27 Is m r traum		19a. Informant's Name/Relation  Betty Felton / 1								i <i>g</i> hts: M			Code)
Jore,	0 0	8	20a. Method of Disposition 1 Burial 2 Crematic		State 20b. P	lace of Dispo			)		Date		tion - City or To	
Baltimore,	permit. Pag Department Importent: I any injury o		4 Donation 5 Other 21. Signature of Funeral Serv		or P. D	oda cr	2. Name and	Addres L	s of Facilit	ens 1	Funeral ue, Bal	Home	, Inc.	wnship, MI 230
	*		23a. Part1. Enter the disease shock, or heart failure.	or complications that call ist only one cause on a	each line.	h. Do not en	ter the mode	of dying						Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	(or all a conseq	Ttws uence of):	ION	3						-
	Examiner	ler.	Sequentially list conditions, if any, leading to immediate	b. Due to	STR0 (or as a conseq	uence of):								
	ate be exacuted hysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	Or as a conseq	uence of):	A							
68760,	physicies the burns the burns	icai		d.										
P.O. Box 6	Physicien: The law requires that the death certificat this certificate has been signed by the attending phy rail director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown	1 ☐ Live I	tcome of pregna birth 2  Feta nant at time of d	Ideath 3[	□Ectopic pre □ Other (spe					230	d. Date of delive Month	ery Day Year
	w requires that baen signed by should be deta	by	Part II. Other significant con-	ditions contributing to d	leath but not res	ulting in the u	inderlying car	use give	en in Part I.		23e. Did to	1		he cause of death?
al Records,	icien: The law re certificate has be rector, page 2 sh	Completed									24a. Was autop perfor 1 Yes	mod? 2000	24b. Were auto prior to co death? 1 \( \text{Yes}	psy findings available mpletion of cause of
f Vital	ysicien: is certific director.	o Be	25. Was case referred to med examiner?  1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	A Othe			n <i>(Check only o</i> me 5 ☐ Resid		Other (Specif	y) House
on of	Jing After fune	lon: T	27. Manner of Death  1 Statural 5 Per	28a. Date (More	of Injury oth, Day Year)	28b. Time of Injury	of 28	Bc. Injury Work	at c? Yes 2□		28d. Describe h	ow injury o	occurred	
Division	Atten r deat sctor: by the	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be 28e. Place	e of Injury - At he ling, etc. <i>(Specif</i>	ome, farm, st			.03 2	-	28f. Location (S City or Tow	itreet and f n, State)	Number or Rura	al Route Number,
_	To the Hospitel or within 24 hours after To the Funerel Director completely filled in the Funerel Director of the Funerel Dire	Medical C	29a. Certifier 12 erti (Check only 2 Medi	fying Physician: To the cal Examiner: On the band man	e best of my kno pasis of examina oner stated.	wledge, deal	th occurred a evestigation, i	it the tim	e, date an pinion, dea	nd place, ath occurr	and due to the o	cause(s) and date and pl	nd manner as s lace, and due to	tated. o the cause(s)
)	To th within To th	Me	29b. Signature and title of cer	ifier Rot	mc	,			8L/	6			signed (Month, n BER	
	W"		30 Name and address of per BERNAND 1-	RYTUVTE	se of death (Item	23a) (Type	Print)	HI	RAVE	JB	IVD Su	116	208-A B	2,200-1 PHIT, M 225 MD 21239
	Sta Regist	ate rar	31. Date filed (Month, Day, Y	8 2004 32. F	Registrar's Signa	ature B	Sp	ak.	á l					301. 7

Geneva & Sparks

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DECEMBER

DHMH 17 Rev 1/2001

Registrar

DEC 0 8 2004

			For State Registrar	State	of Mar	ylan				ealth a		lental Hy	•	2001.	38813
			Registrar  1. Decedent's Name (First, Midd	le ( ast)				uncai	01 1	Jeann		2. Date of De	Reg. No	- 0 0 γ	3. Time of Death
	Physicia	an	Walter	^	0 150							Month 12	Day O 2		( 4 ) M
3	/Medic Examin		4a. Facility Name (If not institution					4b. City	Town, or	Location of	of Death	12		. County of Deat	
	LXamiii	C1	UMMS					B	a 1-	time	ore			NIA	
	Funeral		5. Social Security Number	6. Sex			ast birthday)	If Unde Months	r 1 Year Days	If Under Hours	Min	8. Date of Bi	v Yearl	Co	hplace (State or Foreign untry)
	Director		239-62-8451	1 <b>X</b> M 2□1		62	Yrs.	111011110				FEB. 1	6,1	942 N.	CAROLINA
	and *	}	Usual Residence of Decedent 10a. State 10b. Count	/		l0c. City	, Town or Lo	ocation							10d. Inside City Limits
	Aaryli f sho	៦		I/A		RΔ	LTIMO	)RE							1 XYes 2 □ No
	28a-	Director	10e. Street and Number						p Code				10g. Cit	izen of What Co	untry?
	3a or		305 S. HIGHI	AND AVE	E. A	PT.	#1		212	24			U	.S.A.	
	death ms 2	Funeral	11. Marital Status	12. Was E	ecedent Ev			Was Dece	ident of Hi	ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	<b>)-</b>	14. Race - Ame Black, White	
9	or Ite	正	1 ☐ Never Married 2X Ma	rried 1 □ Y	es 2 🔼 No			1 🗆 Yes		Specify:		, , , , , ,		Specify:	0, 0.0
8	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show pical Exprimetry ast be notified at	d by	3 Widowed 4 Divorce	d Year	or Dates:		16a, Dece			-4:			1 405 16	WH and of Business/	ITE
5	d within 72 ho piene. It than "natur It e Medical	Completed	(Specify only high				(Give	kind of w DO NOT t	ork done d	durina mos	t of work	ing	100. K	and of business	industry
12	within ene. than "	duo	Elementary/Secondary (0-12)	Colleg	e (1-4or 5+)	)	LABO						CO	NSTRUC	TION
0	Hyg Than	a l	17. Father's Name (First, Middle	, Last)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		18. Mothe	er's Nam	e (First, Middle			
an	Tab e	To B	ROBERT LE	ROGE	RS					EAT	ΤA	JANE	HU	NTER	
Maryland 21215-0036	s 1 and 2 should f Health and Men Itam 27 Is marke other traumatic	-	19a. Informant's Name/Relation	ship (Type, Print)			19b. Maili	ng Addres	s (Street a	and Numbe	er or Rui	al Route Numb	er, City o	or Town, State, Z	Zip Code) 21224
	s 1 and 2 of Health itam 27 I other tra		CLARA ROGERS	S/ WIFE		,	_			LAND				1,BALT	
ore	m O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal fr	om State	C	lace of Dispe emetery, cre	matory`or	other plac			Date		ocation - City or	
Ë	Pages ment of l tant: If it		`4 Donation 5 ☐ Other	Specify)		CED						/7/04	GLE	N BURN	IE,MD.
Baltimore,	permit, Page Department ( Important: If any injury or		21. Signature of Funda Service	e Licensee	1			TILL.	Y &	ss of Facili ZEIL	ÆR	INC. H	UNE	RAL HO	ME
	703 e 0		23a. Part1. Enter the disease,	av complications th	at caused t	ho doat								O.,MD.	21224 Approximate
			shock, or heart failure. Li	st only one cause	on each line		ii. Do not en	ter the mo	de or dyni	g, such as	cardiac	or respiratory e	111631,		Interval Between Onset and Death
N	Physician /Medical		disease or condition resulting in death)	a	to (or as a	tay	e Liv	er 1	1150	ase					
	Examiner			L	10 (01 as a	COIISEQ		Circ	hat						
W.		ĕ	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a	conseq		CITI	1103						
	cuted	Examiner	Cause (Disease or injury that initiated events	c											
oʻ	be executed sician and burial-transit		resulting in death) Last	Due	to (or as a	conseq	uence of):								
8760,	ate hy the	dicai		d											
x 68	n certific anding p use as	Physician/Med	IF FEMALE:	23c If vas	, outcome o	f nreans	incv							23d. Date of del	ivon
Вох	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	100	ve birth 2	Feta	I death 3	□Ectopic p		1				Month	Day Year
o.	that the de ed by the detached	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nknown				,,,,,						
4	res that the igned by be detact	by Pt	Part II. Other significant condi	tions contributing	to death but	not res	ulting in the	underlying	cause giv	en in Part	I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	quires n sign	od b	ESRD SIP (	adaver	cre	nal	trans	plan	+			1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
Records,	aw requii as been s 2 should	olete						•				24a. Wa:		24b. Were au	utopsy findings available completion of cause of
Re	The lav	Completed											ormed?	death?	
Vital		BeC	25. Was case referred to medic	al						26. Place	e of Dea	th (Check only			
of V	S .5 .5	To	examiner? 1 ☐ Yes 2 🕱 No		I Minpatien		ER/Outpatie	nt 3 🗆 🗅	Laboration to the	4 _ N	ursing H			6 ☐Other (Spe	city)
n 0	Jing Ph J. After th funeral		27. Manner of Death  1 Natural 5 Pend	28a. C	ate of Injury Month, Day	Year)	28b. Time of Injury		28c. Injur Wor			28d. Describe	how inju	ry occurred	
Sio	Attending or death, ector: After by the fune	cati		tigation				М		Yes 2	No	204 Location	(Ctrant a	ad Alumbas as O	ural Route Number,
Division	l or Attendi after death. Director: A	Certification:		mined 286. F	lace of Injur uilding, etc.	y - At h (Specif	ome, farm, s y)	treet, facto	ry, office			City or To			urai noute number,
	pital ours a aral [		29a. Certifier 1 ☐ Certify	ring Physician: Te	the hest of	my kno	wiedne dea	th occurre	d at the tir	ne date a	nd place.	and due to the	cause(s	and manner as	s stated.
	To the Hospital or Attending Ph within 24 hours after death, To the Funatal Director: After th completely filled in by the funeral	edicai	(Check only 2 Medic one)	al Examiner: On t	he basis of e manner stat	examina	ition and/or i	rvestigatio	n, in my o	pinion, dea	ath occu	red at the time	, date an	d place, and due	to the cause(s)
	ro th vithin ro th	₹ S	29b. Signature and title of certi	ier			· · · · · · · · · · · · · · · · · · ·	2	9c. Licens	e number			29d. Da	ate signed (Mont	h, Day, Year)
	7		) den	zk		4	Mp	A	44171	6435K	. 1586	,cj	12	102/04	
	10		30. Name and ddress of person	n who completed	cause of de	ath (Iter	n 23a) (Type	, Print)							11000
_	١		Stacy Ken	nedy	UMN	S	22 S.	Gree	ne S	to, B	alt	more	, MI	0 2120	1
		ate	31. Date filed (Month, Day, Yes	(r)	. Registra	r's Signa	ature	all a							
	Regist	rar	DEC 0 8	7804	Proceeded.	10	1600								

			For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H			jiene eg. N2 0 0	4	3881	L.
	Physici		1. Decedent's Name (First, Middle Irene E. Syms	le, Last)		-		2. Date of Dea Month 12/1		Year	<ol> <li>Time of Deat</li> <li>2:59cm</li> </ol>	th M
	/Medic Examin		4a. Facility Name (If not institution 1114 Silver Leaf		·)	4b. City, Town, or	Location of Deat	n	4c. County of	f Death Arunda	_	
	Funeral Director		5. Social Security Number 185–20–3775	6. Sex 7. A	ge (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	, <sub>Year)</sub> /1919	9. Birthplac Country	ce (State or Fore	віgn
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					10d	I. Inside City Lim	
	the Ma	Director	NJ 10e. Street and Number	N/A		Washing 10f. Zip Code	gtan TWP		log. Citizen of Wh	nat Country	Yes 2□ √?	No
	23a or	ral Di	433 Hurffville-Gre	enloch Road		08080	)		US	\$A	<u></u>	
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural, or liems 23a or 28a-f ahow other traumatic event, the Modical Exeminent must be notified at other traumatic event, the Modical Exeminent must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	i? ]No	Was Decedent of Hi. If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- o Rican, etc.)		- American , White, etc Bla	c.	
21215-0036	n 72 ho i "natur	oleted	(Specify only highe	nt's Education est grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	lurina most of wo	rking	16b, Kind of Bus	iness/Indu	stry	
	led within ygiene. har than " it, the Wes	Completed by	Elementary/Secondary (0-12)	College (1-4o	•	gistered Nur		(C) A 4 (1-4)		Nursin	g	
land	ould be fil Mental H varkad ott varic evan	To Be	17. Father's Name (First, Middle, Ellison Simor				Edith Ha	ne (First, Middle, IMM)	maiden Sumame,	,		
Maryland	12 shou h and M 7 is mar rraumat		19a. Informant's Name/Relations Douglas Lott / Na			ng Address (Street a				tate, Zip C	ode)	
ď.	of Healtlitam 2	-	20a. Method of Disposition		20b. Place of Dispo		1	Date PD 210	20c. Location - C	ity or Towr	n, State	
Baltimore,	permit. Pages 1 Department of H Important: If ita any injury or ot once.		1 Burial 2 Cremation  4 Donation 5 Other (3		Bayview Cm	ematory Dec 2. Name and Addres	pember 2,	2004	Baltimor	e Mary	1and	_
Bal	Depar Impo any ir		21. Signature of Funeral Service	VICTOR 1		Charles L. S 1501 Fast Fo	Stevens Fu					
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on each	ed the death. Do not en					A Ir	pproximate nterval Between Inset and Death	h
8760,	ite be executed sysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Undorwing Cause (Disease or injury that initiated events resulting in death) Last	C	is a consequence of):							
.O. Box 6	that the death certificate ed by the attending physi detached for use as the	by Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		C.10	23d. Date Mont	of delivery h Da	ay Year	
<b>Q</b>	sign sign d be		Part II. Other significant condit	ions contributing to death	but not resulting in the o	underlying cause give	en in Part I.		bacco use contrib es 2 □ No 3	oute to the	V	
al Records,	The law ate has b page 2 st	Completed							sy pri med? de 2 No 1	ior to comp ath?	y findings availa letion of cause No	ible of
f Vita	Attanding Physician: Thr death. sctor: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tient 2 ER/Outpatie	nt 3□ DOA Othe		ath (Check only or fome 5 \subsetence Resid		(Specify)	Nephews	
o uc	ding Phys		27. Manner of Death	28a. Date of Ir (Month, I	ojury 28b. Time o Injury	Work	rat ⟨? Yes 2 □ No	28d. Describe h	ow injury occurred	d	nie	
Division of Vital	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fo	Certification:	3 Suicide 6 □ Could	not be 28e. Place of	njury - At home, farm, si etc. <i>(Specify)</i>		. 55 2 2 3 10	28f. Location (S City or Tow	treet and Number n, State)	r or Rural F	Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical (		ing Physician: To the be I Exeminer: On the basis and manner	of examination and/or in							
	To th withir To th comp	Me	29b. Signature and title of certific	er	1)	29c. License	number	~)   <sup>2</sup> / <sub>1</sub>	29d. Date signed	(Month, Da	y, Year)	/
	01	1	30 Name and address of person	n who completed cause o	f death (Item-23a) (Type	, Print)	) ( ) ()	/ (	J. R.	M C	17101	-/
	. Sta		31. Date filed (Month, Day, Yea.	0 8 2004 b	strar's Signature	5 Spor	Ks U	IVT	- ILNU W	vivey 4	7-406	7

	1	For State Registrar  1. Decedent's Name (First, Middle, Last	State of Marylan		tificate			Reg	. No. <	004	388   3. Time of Death
Physicia	an		nmons					November	30,	2004	9:00 A
/Medic		4e. Facility Name (If not institution, give			4b. City, Tox	wn, or Loca	ation of Deeth			unty of Death	
Examin	eı	Laurel Regional			Laur	re1			Pri	nce Ge	orges
Funeral Director		239-66-0549	9x ☐ M 2	last birthday) Yrs.	If Under 1 Y Months D		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, 6/2/194	(ear)	Cour	ece (State or Fore etry) n Carolin
*	<u> </u>	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limi
oh a	ō	Maryland Prince	Georges L	aure1							1 ☐ Yes 2 ☐ f
288-	Directo	10e. Street and Number	-		10f, Zip Co	ode		10	g. Citizen	of What Cour	ntry?
3a or		10402 Snowden Ros	ad		20.	708			U	SA	
Department of Health and Mental Hygiene. Important; or Items 23s or 28s-f ehow Important: If item 27 is marked other than "natural; or Items 23s or 28s-f ehow any injury or other traumatic event, the Mudical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marned	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 22 No If Yes, Give			t of Hispan Cuban, M	nic Origin? (Spexican, Puerto Decify:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, ecity: Afr	
Esa	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								
ne. han "nati a Modica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual C kind of work o DO NOT use i tician	done during	g most of wor	king		of Business/In vate	austry
Hygie other t	ပိ	17. Father's Name (First, Middle, Last)		рте	LICIAII	18.	Mother's Nan	ne (First, Middle, M			
Mental Parked of	To Be	Luther Lashley	Sr.				Vict	oria Arri	ngto	n	Code
raum		19a. Informant's Name/Relationship (						ral Route Number,			Code)
Healti Pm 27 ther 1	1	Evelyn Hawkins - 20a. Method of Disposition					Rd; La	urel MD 2	_	ion - City or To	wn, State
nent of h ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐	Hemoval from State	Place of Dispo cemetery, crea			1				
rtant	1	*4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	Fo	rt Lin	coln Ce	emete	Facility	7472004		twood,	
Depa Impo any is		Myelin T. K	lobert	3	401 Bla	adens	burg R	Fort Linc d; Brentw	ood		22
ysician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Stroke		er the mode o	or aying, su	ich as cardiad	or respiratory arres	it,		Approximate Interval Between Onset and Death
Medical caminer	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Myocardial Due to (or as a consect	Infarc	tion						
hysician and he burial-Iransit	ical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec								
the attending pl hed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2€ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of 6 9 Unknown	el death 3	Ectopic preg				230	. Date of delive Month	ary Day Year
pg ag	by	Part II. Other significant conditions of Hyperlipidemia	contributing to death but not res	sulting in the u	inderlying cau	se given in	Part I.	23e. Did toba	_		he cause of death pably 4 DUnkno
been s should	ompleted	Renal Insuffic	iencv					24a. Was an		4b. Were auto	psy findings avail
ate has page 2	E G		<u> </u>					autopsy perform	ed?	death?	mpletion of cause 20300
certificate rector, pag	O	25. Was case referred to medical				26	. Place of Dea	ath (Check only one			
direct	To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 X Inpatient 2	] EP/Outpatie	nt 3 DOA	Other:	↓ Nursing H	lome 5 ☐ Resider	nce 6	Other (Special	<i>(y)</i>
h. Alter th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o Injury	of 280	Work?	2 🗆 No	28d. Describe how	v injury o	ccurred	
s after deatl If Director: od in by the	Certification;	3 🗍 Suicide 6 🗎 Could not be determined		nome, farm, st ify)	reet, factory, o	office		28f. Location (Str. City or Town,		lumber or Run	al Route Number,
within 24 hours after de To the Funeral Directo completely filled in by th	edical C		nysicien: To the best of my kn miner: On the basis of examin and manner stated.								
within 2 To the comple	Me	29b. Signature apolyitle of certifier	Phlico	ne	29c. l	License nu	323		d. Date s	igned (Month,	Day, Year)
ix		30. Name and address of person and	completed gause of reath (Ite	m 23a) (Type	, Print)	_	, /	imme	/	A	-

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death STEVENSON December **Physician** \*Phanie 2000 /Medical 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BON SECOUR NIA Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🗹 F 217-88- 6814 40 Yrs. Director MD 10.11.64 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10h Counts 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f show other treumatic event, it a Modical Execution must be notified at MD Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 148 S. KOSSUTH STREET U.S.A. 21229 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 131 ACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSUS ASSISTANT HEALTH CARR 11th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If Item 27 is marked othe any Injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie diver Mary Bowman ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 148 S. Kussuth Street Baltimore, MD 21229 Mary Dliver Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 SPBurial 2 ☐ Cremation 3 ☐ Removal from State 12.10.04 Baltimore, MD MT. ZION 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. CREENE FUNERAL SERVICES STOLL BULLTUNERE NUT'L PILE BALLO, MD 21229 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death END Immediate Cause (Final OCGENCED Stag 1 immuno de **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 2 3 No Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 2 🗆 No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 2000 West Baltimore UXUYNO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 8 2004

			For State Registrar	State of Mary		artment of H <i>rtificate of L</i>			jiene 2004	38817
			Decedent's Name (First, Middle, La	nst)	-			2. Date of Dea		3. Time of Death
	Physicia /Medic	ai .	JOSEPHINE ANN			T		De c	Day Year 2 2 3	
	Examin	er	4a. Facility Name (If not institution, gi				Location of Death IMORE		4c. County of Dear	n
_			802 S. KENWOO  5. Social Security Number 6.		n yrs. last birthday		If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Funeral Director			1 DM 0BR	35 Yrs.	Months Days	Hours Min.	(Month, Day 2 / 2 7 )	/19 MAR	YLAND
		t	Usual Residence of Decedent							
	ylan,		10a. State 10b. County	10	Dc. City, Town or L	ocation				10d. Inside City Limits 1 ⊠Yes 2 □ No
	e Ma	Ş	MD	N/A	BA	ALTIMORE				
	or 28	Director	10e. Street and Number			10f. Zip Code	0.7	1	10g. Citizen of What Co USA	ountry?
	ath w		802 S. KENWOOD		15-110	212		anti-Van as Na	14. Race - Ame	rican Indian
	er de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ②No	or in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Whit	
3	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ௸ No	Specify:		Specify: W	HITE
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examiner must be multified at		15. Decedent's f	Education	16a. Dece	edent's Usual Occupa kind of work done of	ation	ina	16b. Kind of Business	Industry
בן ב	thin 7 e. en "n Med	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)	,,,d	THOREDN	ELECTRIC
	filed within Hygiene. other than	Son	6	0			10.11 (1) (1.11)	- (First A Color)		ELECTRIC
	be filed within 72 ho ital Hygiene. od other than "natur evant, Ite Medical	Be	17. Father's Name (First, Middle, Las				18. Mother's Name	BISKU		
Maryland		ို	STANISLAUS LI		10h Mail	ing Address (Street			r, City or Town, State, .	Zin Code)
<u>a</u>	d 2 sh h and 7 Is n traun		19a. Informant's Name/Relationship	(1998, PAIN) (OZLAKOWSK)					N, MD. 21	
	is 1 and 2 should of Health and Mer item 27 Is marke other traumatic		MRS. SHIRLEY B		20b. Place of Disp	osition (Name of		Date	20c. Location - City or	
altimore,	00		1 🗷 Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spec			omatory or other plac NISLAUS	12/7	/04	BALTIMORE	E, MD.
	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Life	~		ACZOROWS			ME P.A.	
ä	ong any		Cura	Caro					IMORE, MI	21222
			23a. Part1. Enter the disease, or co shock, or heart failure. Listyon	mplications that caused the	e death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
z	Physician		Immediate Cause (Final disease or condition	GI	Blee	dins				Onset and Death
	/Medical		resulting in death)	Due to (or as a c		0				
	Examiner		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c						
	ed ist	niner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence on.					1
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):					
8760,	e be e siciar e buri	dicai E	•	d						
89	ifficati g phy as the	00	- 1							
ŏ	th cert endin r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		☐Ectopic pregnancy			23d. Date of de Month	livery Day Year
P.O. Box	The law requires that the death certifis are has been signed by the attending I page 2 should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at tim 9□ Unknown	ne of death 5	Other (specify)			WOULD	5 <b>u</b> ) 10u
<u>Ч</u>	nat Ihe d by t letach	Phy	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause civi	en in Part I.	23e. Did to	bbacco use contribute to	the cause of death?
ds,	ires the signer signer d	l by	Denesti	-	1026C		er Dis	1 U Y	′es 2.24¶o 3⊟P	robably 4 Unknown
Ö	w require been si should I	etec	HTAL			,	-(	24a. Was a	an 24h Were a	utopsy findings available
of Vital Records,	has ge 2	Completed						autop perfor	sy prior to med? death?	completion of cause of
<u></u>			25. Was case referred to medical				26. Place of Deat	1 ☐ Yes		2,50
5	Physician: r this certific ral director,	o Be	examiner? 1 \sum Yes 2 \sum No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Oth	er: 4 🗆 Nursing Ho	ome 5 Nesid	tence 6 Other (Spe	cify)
	g Physical seral s	ı.	27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Time Injury		y at k?	28d. Describe h	now injury occurred	
<u>ö</u>	Attanding ir death. ector: Afte by the fune	atio	1 Natural 5 Pending investigat	ion		M 1 🗆	Yes 2 □ No			
Division	or Atta	Certification:	3 Suicide 6 Could not determine			treet, factory, office		28f. Location (S City or Tow	Street and Number or R m. State)	ural Houte Number,
	pital o		29a. Certifier Certifying	Physician: To the best of r	my knowledge, dea	ath occurred at the tin	ne, date and place.	and due to the	cause(s) and manner a	s stated.
	To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Ex	aminer: On the basis of exand manner state	xamination and/or	investigation, in my o	pinion, death occur	red at the time, o	date and place, and du	e to the cause(s)
	Fo the	Me	29b. Signature and title of certifier	. 0		29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
	1		Mast n	Milerey	Mg	D	4575	7	Dec 3,	2004
	V		30. Name and address of person who Matthew	Mc N = 4~	th (Item 23a) (Type	9, Print) 940 E	estern	De	Balt 1	MD 21224
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	Ann v				
	negisi	त्वा	DEC 087	.004	La.	July Constant	W			

Salcourtei

			State of Maryland / Department of Health and N  1- For State Registrar AMEND ITEM #1 PER PHY G840 29011/05aten for Death	_		4 38818
			Decedent's Name (First, Middle, Last)     RAYMOND SCHULER	2. Date of Dea	ath	3. Time of Death
	Physicia		RAY MUND SCHULER	Month		fear 3 33 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of	
	Examin	Ġı	BON SECOURS HOSPITAL BALTIMON	E	N	/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birt	h c	9. Birthplace (State or Foreign
	Director		215-46-5783   183 M 2 F   57   Yrs.   Months   Days   Hours   Min.	1-23-4	7 Year)	Country) Iarvland
			Usual Residence of Decedent		1 1	latytanu
	ylan		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ma-fe	cto	MD N/A Baltimore			Yes 2□No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
	within 72 hours after death with the Maryland ene. than "netural", or tlems 23a or 28a-f ehow the Modical Eracilier mata be notified at		328 South Bruce Street 21223		U.S.A.	
	dea	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No o Rican, etc.)	- 14. Race -	American Indian, White, etc.
9	or the	F	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No Unknown 1 ☐ Yes 2 ☒ No Specify:		Specify:	
8	urat',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			White
ů.	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	king	16b. Kind of Busi	ness/Industry
2	Althin han han	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		Construc	ation
7	filed v Hygie other t		12 Carpenter  17. Father's Name (First, Middle, Last) 18. Mother's Name	ne /First Middle	Maiden Sumame)	
no	be find the	Be				
3	should be filed withir ind Mental Hygiene. s marked other than umatic event, I'R M.	오				to the Control
Maryland 21215-0036	12 s h ar 7 is rau		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Elsa Keene/Daughter  19b. Mailing Address ( <i>Street and Number or Ru</i> 7854 Mansion House Cro			
	an Heal m 2 her	}	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - C	
altimore,	nt of it.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State   cemetery, crematory or other place)			•
tim	t. Pa ntmer ntant	1	Donation 5 Other (Specify)  Bayview Crematory, Inc. 12	-6-2004	Baltimo	re, MD
Bal	permit. Pages to Department of Hamportant: If ite any injury or ot once.	(	21. Standard of Francisco Standard Control of Standard Control of Francisco Standard Control of Standard C	ne_of_La	nsdowne	1 01007
	40244		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Q ZIZZ/ Approximate
			shock, or heart failure. List only one cause on each line.	or respiratory ai	1651,	Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)  a			
	/Medical Examiner		Due to (or as a consequence of):			
		<u></u>	Sequentially list conditions, b. ALCOHOLIC ZIVER DIS	EASE		
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
_	and and Il-trar	Examin	that initiated events c.  resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	aiE				
387	cate phys the	dicai	d			
9 X	eath certific attending p I for use as 1	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date	of delivery
Вох	atter for u	cian	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy		Monti	,
o.	the d	Physician/M	1 U Yes 2 No 9 Unknown			
<u>α</u>	res that the de igned by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
ds	uires sign ld be	d by	RESPIRATORY FAILURE	10	Yes 2□No 3	☐ Probably 4 KUnknown
Ö	v requir been s should	iete	ASPIRATION PNEUMORYA	24a. Was	an 24b We	ere autopsy findings available
Vital Records,	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Completed		autor	rmed? pri	or to completion of cause of ath?
a	(0 ==		16N/R FAILURE	1 Yes		Yes 2 No
V.	Physician: this certificant director,	Be c	examiner? Hospital: 4. Other	ath (Check only o		(Const.)
of	ding Physician: n. After this certific funeral director,	1: To	27. Manner of leath 28a. Dite of Injury 28b. Time of 28c. Injury at		now injury occurred	
on	ding F h. After funera	tior	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division	death death ctor: y the	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office			or Rural Route Number,
Ω	after Dire	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Tox	vn, State)	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier  (Check only   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	, and due to the	cause(s) and manr	ner as stated.
	A Ho	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	rred at the time,	date and place, an	d due to the cause(s)
	To th withir. Fo th	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (	
			15mely no D30272		12/02	12000
	.5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1
			JSmully MO D30272  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  THOMAS S. MIUVEN BON SECOUPS 14	OSPITAL	- BAZ	TIMORE, MD
	∂ Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist		DEC 0 8 2004 Server 10 Missess			

		•	1 - For State Registrar		aryland / Dep Ce		of He	ealth a		ental Hy		004	38819
	Physicia	an	1. Decedent's Name (First, Middle, Last)						2	Date of Da Dec.	ath 6Day	200 <sup>2</sup> 4°	3. Time of Death
	/Medic Examin	al	William T.  4a. Facility Name (If not institution, give:			4b. City, To	own, or l		f Death	Dec.		County of Dea	4:00pm M
			15210 Old Frederick  5. Social Security Number 6. Sep		a (In yrs. last birthda)			If Under 2	24 Hrs.   p	Date of Bir	th		thplace (State or Foreign
	Funeral Director			]M 2□F	72 Yrs.		Days	Hours	Min.	B. Date of Bir March March	13°,	1932 C	nungar)
	yland yland		10a. State 10b. County		10c. City, Town or I	Location							10d. Inside City Limits
	Be-1st	ctor	MD Howard		Wo	odbine							1 ☐ Yes 2 📉 No
	3a or 26	al Dire	10e. Street and Number 15210 Frederick R	oad		10f. Zip C	217	97			10g. Citiz	en of What Co USA	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If Item 27 is marked other than "natural", or Items 23a or 28e-f show ship injury or other treumatic event, I'm Medical Examinal must be rudified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decede If Yes, specif			gin? (Spec , Puerto Ri	ify Yes or No ican, etc.)		4. Race - Ame Black, Whit Specify:Whi	te, etc.
21215-0036	72 hour	ted b	15. Decedent's Edu (Specify only highest grad	cation	16a. Dec	edent's Usual	Occupa	tion	of working	7	16b. Kin	d of Business	/Industry
121	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	e kind of work DO NOT use					٨٨٠	ricultu	ıro
	filled v Hygie Sther t	e Co	12 17. Father's Name (First, Middle, Last)		L Cat	tle Bre			r's Name (	First, Middle,			ire
/lan	should be filed nd Mental Hygi marked other umatic event,	To Be	Guy Stewart	Stanton				A1mi	ira Tı	urner	_		
Maryland	12 sho h and l ls ma reuma		19a. Informant's Name/Relationship (Ty Mrs. Holly Harbula			iling Address ( Tufts						Town, State,	Zip Code)
	Health tem 27 other tre		20a. Method of Disposition		20b. Place of Dis				Da			cation - City or	Town, State
MO	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Eremation 3 ☐ F  1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	All Coun				12/7/:	2004	Syke	esville	e, MD
Baltimore,	permit. Pages 1 and Department of Health Importent: If Item 27 eny injury or other tr 9008.		21. Signature of Funeral Service Licens	Hause								(Box 195-1400	95)
	Pnysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Can	the death. Do not e	fact	of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
1760,	Ite be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	too Cu	4	Dise	elso				7 (year
P.O. Box 68	es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	B⊟Ectopic pre B⊟ Other (spe					2	3d. Date of de Month	livery Day Year
	requires that the been signed by th hould be detache	by	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the	underlying ca	use give	n in Part I.		1	obacco us		o the cause of death?
Records,	sicien: The law requir certificate has been si irector, page 2 should I	Completed							_	24a. Was auto perfo		24b. Were a prior to death?	utopsy findings available completion of cause of
Vital	Physicien: this certificatal director, I	Be	25. Was case referred to medical examiner?	Hospital:			Otho			(Check only o			
of	Phy rthis ral d	lon; To	27. Manner of Death  1 Natural 5 Pending	1 Inpatie 28a. Date of Inju (Month, Da	ent 2 ER/Outpat ry 28b. Time y Year) Injury		c. Injury Work		28	e 5 A Resi 3d. Describe		Other (Spe	ocify)
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)				_	Bf. Location ( City or To			ural Route Number,
	Hospite 24 hours Funerel etely filled	Medical C			of my knowledge, de f examination and/or ated.								
	within To the compli	Me	29b. Signature and title of certifier			1		number			29d. Date	signed (Mon	th, Day, Year)
	7		Vater T				1) 20	1806			12/	7/04	
_	10		30. Name and address of person who co			e, Print)	RD	E	LOU	es bullo	we	0 217	Ry
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	<u>,</u>		,					

DHMH 17 Rev 1/2001

DEC 0 8 2004

Serve Brands

			-	State of Marylan					-					
			1 - For State Registrar	otate of warytan			e of De			Reg. No	- m	20000		
			Decedent's Name (First, Middle, Last)     2. Date of Death									3. Time of Death		
	Physic /Medi		Christine	Shaw					Decemb	Da OCT	Year 200			
7	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Los	cation of Death		40	. County of De			
			Johns Hopkins +	Bayview Medic				nore						
	Funeral Director		5. Social Security Number 6. Se 178–32–5573	7. Age (In yrs.)	last birthday) Yrs.	If Under Months		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da	ay, Year)		inthplace (State or Foreign Country)		
			Usual Residence of Decedent	02					June 2	/,19	42 Per	nnsylvania		
	hours after death with the Maryland turei', or items 23a or 28a-f show al Exatric at must be motified at		10a. State 10b. County	10c. City	y, Town or Lo	ocation						10d. Inside City Limits		
	Ba-fs	cto	MD Anne Ar	undel Se	evern							1 □ Yes 2XXNo		
	in 72 hours after death with the Marylan "neturel", or Itema 23a or 28a-1 show idical Examinat the indillad at	To Be Completed by Funeral Director	10e. Street and Number			10f. Zip	Code			10g. Cit	tizen of What C	Country?		
	eath va 23g		1225 Pine Cone C	ourt  12. Was Decedent Ever in U.	S 40.1	Man David		144			USA			
<b>'</b> 0	fter d		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ☐ Yoo	3. 13.	Yas Deced	of thispa	nic Origin? (Sp lexican, Puerto	ecify Yes or No Rican, etc.)	>-	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>			
93	ours a		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No Specify:					Specify: White			
21215-0036	C1 60 14		15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usua	n a most of work	king 16b		. Kind of Business/Industry				
121	d within 7 jiene. r then "n		Elementary/Secondary (0-12)	College (1-4or 5+) /ife. DO NOT use retired)					9					
d 2	be filed value Hygie od other terminal		17. Father's Name (First, Middle, Last)	Homemaker 18 Methods					e (First, Middle	wn Home				
an	Q 20 0		John E. Onifer							, waiden	ien Sumame)			
Maryland	S E E		19a. Informant's Name/Relationship (T)	Type, Print) Eileen Cowen  19b. Mailing Address (Street and Number or Rural Route Number, City or Tox								Zip Code)		
	1 and 2 Health a tem 27 is		Bruce W. Shaw (H	·	1225	Pine	Cone	Court,	Severn,	MD	21144			
Baltimore,	iges 1 and of Heali if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ F	20b. P	lace of Dispo emetery, cren	sition (Nam natory or ot	e of her place)		Date		ocation - City o	r Town, State		
Ē	permit. Pages of Department of Himportant: if ite any injury or of once.		*4 □ Donation 5 □ Other (Specify)	Me	tro Cr	emato	ry	12/6	/2004	Balt	timore,	MD		
Bai	Departition Depart		21. Signature of Funeral Service Licens	60/		Harde	Address of	uneral	Home, F	. A .				
		$\vdash$	23a Part 1 Enter the disease or comp	ications that caused the death		12 Ri	dgely	Avenue	Annap	olis	, MD 2			
	No. atatan	ner	23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	i. Do not ent				or respiratory ai	rrest,		Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)  a. In tracrania Hemorrhage  Due to (or as a consequence of):									hours		
	Examiner			Hunertensim								20 years 20 years		
	T =		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):								7000		
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Diabet	Diabetes mellitus							20 years		
60,	te be executed ysician and e burial-transit	al E	Due to (or as a consequence of):											
68760,	physics the l	dical												
	death certificat e attending phy d for use as th	/Me	IF FEMALE:  23b. Was decedent pregnant  (a) the cost 13 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of delivery			
Box	death e atter	Certification: To Be Completed by Physician/Med	in the past 12 months?	Ectopic pre Other (spe				Month Day Year						
P.O.	t the by the tache		9 Unknown	9□ Unknown										
Ś	w requires that the death been signed by the atte should be detached for		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									o use contribute to the cause of death?		
ord	equir sen si bluoi		Angina pectoris, myocardial infaction 12/400								2 No 3 Probably 4 Unknown			
ec	law law has b		diabetes, hypercholesterolemia, 24a. Was an autopsy								24b. Were autopsy findings available prior to completion of cause of			
a F	r: The			ascular acc	ider	itin	199	4	perfo	rmed? 2.23 No	death?	1		
ξ	Physician: The lav this certificate has al director, page 2 a		25. Was case referred to medical examiner?	lospital:			04		n (Check only o					
Division of Vital Record	r this		1 Yes 2 No	1 poinpatient 2 L	ER/Outpatient 28b. Time of		c. Injury at		me 5 Resid			ecify)		
lon	nding ath. r: Afte e fune		1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	2 🗆 No	, , , , , , , , , , , , , , , , , , , ,								
<u> </u>	Attendi er death. rector: A by the fu	tific	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street arbuilding, etc. (Specify) 28f. Location (Street arbuilding, etc. (Specify)								nd Number or Rural Route Number,			
ā	ital or rs aft ral Dii	Cer							,					
	Hosp 4 hou Funer ely fill	edical	( Interest of the second secon	sician: To the best of my knowner: On the basis of examinati	vledge, death	occurred a	t the time, d	ate and place,	and due to the d	cause(s)	and manner as	s stated.		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Med	one) 29b. Signature and title of certifier	and manner stated.			License nur							
)	F ¥ F 8		Dr. Seema	Sarin				000		ember	onth, Day, Year)			
	6		30. Name and address of person who co		23a) (Type 5	, ,			, ,					
	0		D = 0 = =				10 Eas	tem A	venue.	Ba H	imore, M	10 21224		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure				/		1			
	Registr	ar	DEC 0.8	/1111A 122 nov	mar	17	Some	1						

		1	For State Registrar	State of	Maryland / De	partment of ertificate of			ene 2004 38821	
	Physicia		1. Decedent's Name (First, Midd JoAnn	Kelly	S	ipes		2. Date of Death Month December	Day Year 2:51 p M	
	/Medic Examin		4a. Facility Name (If not institution 1161 Steamb	on, give street and num			or Location of Death		4c. County of Death Anne Arundel	
	Funeral Director	4	5. Social Security Number 570-34-8429	6. Sex 1 □ M 2 X F	7. Age ( <i>In yrs. last birthda</i> 77 Yrs	Months Day		8. Date of Birth (Month, Day, 1) Sept. 6	year) 9. Birthplace (State or Foreign Country) Ohio	
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 ie marked other then "neturel", or items 23a or 28e-f show other treumatic event, I're Medical Exertif er matte notified at	ctor	Usual Residence of Decedent   10a. State	Arundel	10c. City, Town or Shady	Side 10f. Zip Code	764	10	10d. Inside City Limits 1 □ Yes 2 🖫 No g. Citizen of What Country?  USA	
215-0036		by	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4XXPivorce	12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	2 🕅 No e ates:	1 ☐ Yes 2 X N	upation	11	14. Race - American Indian, Black, White, etc.  Specify: White  6b. Kind of Business/Industry	
2121	ed within 7. ygjene. ser then "n t, tre Medi	Completed	Elementary/Secondary (0-12)	4	-4or 5+)	e. DO NOT use reti emaker	ne during most of worked)	me (First, Middle, M	Own Home	
Maryland	12 should be filed within " h and Mental Hygiene. 7 le marked other then " treumatic event, the Mas	To Be	17. Father's Name (First, Middle Neil Michael 19a. Informant's Name/Relation	Kelly	19h M	ailing Address (Stre	Doroth	y Carter	City or Town, State, Zip Code)	
Mai	alth and 2 sh		Robert Sipes					, Daytona	Beach, FL 32114	
lore,	ages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 【Cremation		State cemetery,	sposition (Name of crematory or other p	ı		Oc. Location - City or Town, State	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 le any injury or other tree	İ	21. Signature of Fyneral Service  22. Signature of Fyneral Service	1.0	Metro	Crematory 22 Name and Add Hardest 12 Ride	ress of Facility y Funeral	Home P.A	Baltimore, MD lis, MD 21401	
68760,	the burgal-fransit	dlcal Examiner	23a. Part 1. Enter the disease, shock, or heart falkire. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a	ach line.  Cast Case (or as a consequence of): (or as a consequence of):	er	, , , , , , , , , , , , , , , , , , ,		Interval Batween Onset and Death Two Ye 445	
O. Box 6	it the death certifica by the attending phi tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡No 9 □ Unknown	1 ☐ Live b	come of pregnancy birth 2 Petal death nant at time of death own	3 □Ectopic pregna 5 □ Other (specify,			23d. Date of delivery Month Day Year	
4	ding Physician: The law requires tha n, After this certificate has been signed funeral director, page 2 should be de	by	Part II. Other significant condi	tions contributing to d		acco use contribute to the cause of death? s 2 ⊠ No 3 □ Probably 4 □Unknown				
l Reco		Completed				24a. Was an autopsy perform 1 Yes 2	prior to completion of cause of death?			
ion of Vital Records,		Certification: To Be	2 Accident	Hospital: 1  28a. Date  (Monstigation	04	ath (Check only one)  Home 5 A Residence 6 Other (Specify)  28d. Describe how injury occurred				
Division	i Çife	ertific	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 200, Place	of Injury - At home, farming, etc. <i>(Specify)</i>	, street, factory, offi	се	28f. Location (Str City or Town	eet and Number or Rural Route Number, , State)	
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical C	(Check only 2 Medic	al Examiner: On the b	urred at the time, da	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)				
		Σ	29b. Signature and title of certification	~ P. =	Souls	m P	ense number 38563	1	December 3, 2004	
-	(5)		30. Name and address of personal Name D. B	con who completed cause	se of death (Item 23a) (T	ype, Print) VIIIC RE	D, West a	Ner, n	D 20778	
	St Regist	ate rar	31. Date filed Month, Day, Ye DEC 0	8 2004 32. F	Registrar's Signature	& Spo				

Elmer Maurice Snowden Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04**-**07870 RJState of Maryland / Department of Health and Mental Hygiene 1- State Unpend Item 23a&27 per me G839Celtificate of Death 38822 Rag. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year mea laurice December 6, 2004 0151 /Medical 4a. Facility Name (If not institution, give street and number)
Alley of 5200 block Linden Heights Ave. 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F 214-54-4762 Usual Residence of Decedent Months Days Hours Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore 1 Pres 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 238 JWARD USA Completed by Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: ō Maryland 21215-0036 1 Yes 2 No Black Specify: 3 Widowed 4 Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) OFFICE WORK CORP dyrs 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental P Snowden Pages 1 and 2 should oeights 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. 814 Washington Balto, mo HayWARD Ave - mother 21215 altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Catonsv. 1/e metro Cremator ` 4 □Donation Other (Specify) permit. 21. Signature of uneral Service Licen 22. Name and Address of Facility P. MaRCH the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Cirrhosis of the Liver resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 No 24a. Was an director, page 2 autopsy performed? 2 No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) At Scene Injury at 28d. Describe how injury occurred 1x Yes 2□ No Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Xetural 2 Accident 5 Pending death. investigation 1 Tyes 2 🗌 No filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the h 29b. Signature and title of certified 29c OCME number 29d. Date signed (Month, Day, Year) December 6, 2004 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATRICA ACAL PLANT Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 17 Rev 1/2001

DEC 0 8 2004

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. A. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Harc mar 00:28 M 5,2004 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Itopkins Hospita he John INNOV If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F June 21, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 217-24-3297 Director 74 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Director Md. Baltimore 1 Yes 2 No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 hent of Health and Mental Hygiene. 5 12350 Rosslare Ridge Rd. #104 21093 or Items 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Siltman, Sr. Brittania Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra <u>20058.</u> Mrs. Ann E. Siltman/Wife 12350 Rosslare Ridge Rd. #104 Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Moreland Memorial Park ' 4 Donation 5 Dother (Specify) Dec. 8, 2004 Parkville, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart ONBESTIVE disease or condition resulting in death) lomonths /Medical Due to (or as a consequence of): Examiner SCHEMI Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events nding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery ed by the attended for us 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 2 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Certification: To 1 🗌 Yes 1. Inpatient 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD December 5, 2004 ss of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 600 LI WOLFEST BOCHO, MIDEREN Keza 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

DEC 0 8 2004

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			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar Certificate of Death Reg. 10										2 N N I.	+ 38824			
		7	1. Decedent's Nam	e (First, Midd)	e, Last)							2. Date of De		ay Year		ne of Death	
	Physici /Medic		Norman V	V. Seldo	ı							Horemy					
	Examin	-	4a. Facility Name (/	f not institution	n, give street an	d number)		4b. City,	Town, o	r Location	of Death		4c. County of Death				
			Stella Maris @ Mercy						Baltimore				NA				
	Funeral		5. Social Security N	lumber	6. Sex 1 X M 2□		e (In yrs. last birthda	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year	9. Bi	country)	ate or Foreign	
	Director		218-07-5706		123-141 2		96 Yrs.					05-25-19	908_	Virg	ginia		
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	the 128a-	rect	10e. Street and Nu	mber			I	10f. Zip	Code				10g. C	itizen of What C	ountry?		
	th with	Funerai Director	825 Mt. Ho	11 <sub>17</sub> S+					212	20				USA			
	items 2:	era	11. Marital Status	ily St.	12. Was	Decedent	Ever in U.S. 1	B. Was Dece	dent of H	lispanic Or	igin? (Spe	ecify Yes or No	)-	14. Race - Am		ın,	
36	# 5 E	by Fur	1 Never Marr		ried 1 🔲	ed Forces? Yes 2 Xi s, Give or Dates:	No	If Yes, spe		an, Mexicai Specify:		Rican, etc.)		Black, Wh  Specify: Bla			
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15	be filed within 72 ho ttal Hygiene id other than "natu event, Lre Medical	Completed		cify only highe	st grade comple	eted) ege (1-4or :	(Gi	ve kind of wo . DO NOT u	rk done	durina mos	st of worki	ng			Compar	207	
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ğ	othe othe	BeC	17. Father's Name	(First, Middle,	Last)					18. Moth	er's Name	(First, Middle	, Maiden Sumame)				
lar	fental fental rked c	To B	Ernest S	Seldon							Martha	a Dotson					
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I've My	_	19a. Informant's N	ame/Relations	hip <i>(Type, Print</i>	)	19b. Ma	iling Address	(Street	and Numb	er or Rura	I Route Numb	er, City	ity or Town, State, Zip Code)			
	and 2 salth a n 27 ts		DeVera McC	Cleary/	Daughter		121	6 E. Ma	dison	Avenu	e Bai	ltimore,	1D 21	.202			
altimore,			20a. Method of Dis	•			20b. Place of Dis	position (Nai	me of other place	ce)	C	Date	20c. L	ocation - City o	r Town, Sta	te	
5 E	permit. Pages 1 Department of Hi Important: if iter any injury or oth		1 X Burial 2 ¹ 4 □ Donation		3 □Removal Specify)	from State	Maryland N			1	2-04-(	04	Laur	el, MD			
aĦ	permit. Departmimporta		21. Signature of Fo	ineral Service	Licensee			22. Name ar	nd Addre	ss of Facili	ity						
) m	Ped In Ped			UM	m			Wylie F	unera	1 Home	638 1	N. Gilmon	St.	Baltimor	e, MD	21217	
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S,		by F	Part II. Other signi	ficant conditi	ons contributing	uting to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?						
ord			fro star cary								1 🗆	1 ☐ Yes 2 ☐ No 3 ☐ Probably					
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ita	Physician: Th this certificate al director, pag	Be	25. Was case refe	rred to medica								Check only					
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	To the within To the comp	M	29b. Signature and	title of certific	er			29	c. Licens	e number				Date signed (Month, Day, Year)			
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1	m		30. Name and add	ress of persor	who completed	cause of	death (Item 23a) (Typ	e, Print)	- (								
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<b>)</b>	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o	or Location of Death		c. County of Deeth	A
			Good Samaritan Hos	oital	Baltim			N/A	
	Funeral		5. Social Security Number 6. Sex	** **	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	(r) 9. Birthp	lace (Stete or Foreign
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	ow ow		10a. State 10b. County	10c. City, Jov	vn or Location			1	0d. Inside City Limits
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	or 28.	Director	10e. Street and Number	1	10f. Zip Code		10g.	Citizen of What Coun	ntry?
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	ar des	Funerai		Was Decedent Ever in U.S.     Armed Forces?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
36	rs afte	by F	1 Never Married 7 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: U	hite
8	be filed within 72 hours after death with the Maryland hal Hygiene. od other then "natural", or items 23s or 28s-f show svent, I'm Medical Ezanting must be truffied at	edt	15. Decedent's Educ		a. Decedent's Usual Occup	pation	16b.	Kind of Business/Inc	dustry
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Maryland 21215-0036	E a a		19a Informant's Name/Relationship (Typ	1/	b. Mailing Address (Street	1//	Route Number, City	y or Town, State, Zip	code) 10 21015
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Baltimore,	permit. Page Department o Important: If any injury or ance.		21. Signature of Funeral Service License	The second state of the second second	22. Name and Addre			, Inc. Fune	
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Division	l or Attending after death. Diractor: After I in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f. building, etc. (Specify)	arm, street, factory, office	28	Bf. Location (Street City or Town, Sta	and Number or Rural	Route Number,
	rital or ris aff					- 11			
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination and manner stated	e, death occurred at the tir nd/or investigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stand one to	ated. the cause(s)
	Fo the within 2 Fo the complete	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	29d. E	ate signed (Month, L	Day, Year)
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	m		30. Name and ad ress of person who cor	mpleted cause of death (Item 23a)	(Type, Print)			-	/
			Howard	Steiner	15601 L	och R	avea	Blvd.	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 1				
1	Registr	ar	DEC 0 7 200	G Passan	12 Apark	51			

			1 - For State Registrar	State of Maryland	-	artment of tificate o		Mental Hy	giene Reg. No 2004	38826
ı	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year	3. Time of Death
1	/Medi	cal	Anna Mae Sok  4a. Facility Name (If not institution, give :			4h City Town	, or Location of Dea	Decemb	Der 4 2004  4c. County of Dea	3:15 pm M
	Examir	ner	11540 Philadelphia Rd.			White M			Baltimore	
	Funeral Director		5. Social Security Number 6. Sex		st birthday) Yrs.	If Under 1 Year Months Day	r If Under 24 Hr			rthplace (State or Foreign ountry) timore,Maryland
	/land		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	ith the Marylar or 28a-f show	cto	Maryland Baltimore	Whit	e Mars	h				1 ☐ Yes 2 🙀 No
	or 28	Dire	10e. Street and Number			10f. Zip Code	)		10g. Citizen of What C	ountry?
	s 23e	eral	11540 Philadelphia R		10.1	21162	(1)	0	USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be multified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ XWidowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Mas Decedent of Yes, specify Cu I□ Yes 2 1 N	f Hispanic Origin? ( uban, Mexican, Pue o <i>Specity:</i>	Specify Yes or No rto Rican, etc.)	Specify:	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	lent's Usual Occ	upation se during most of we	odeiga	16b. Kind of Business	
121	within lene. than	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	00 NOT use reti	red)	Jikiliy		
2	Hygien Hygien other th		12 17. Father's Name (First, Middle, Last)	N/A	Cafete	ria Worke		ma /First Middle	Baltimore Co	. School Board
Maryland	ould be f Mental i sarked of	To Be	Dailey E Hershman				Charlene		, maiden Sumame)	
ary	2 should and Menis marker sumatic	1-	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailin	g Address (Stre			er, City or Town, State,	Zip Code)
	1 and 2 Health a am 27 is		Michael Cole (Son)					railer 4A	White Marsh, M	Md. 21162
altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 <b>XXC</b> remation 3 ☐ R	emoval from State	e of Dispo netery, cren	sition (Name of natory or other p	lace)	Date	20c. Location - City or	Town, State
tim	permit. Pag Department Importent: I any injury o		*4 ☐ Donation 5 ☐ Other (Specify)	Metan			_December	6 2004	Baltimore, Mar	ryland
Bal	permit. Pa Departmer Importent any injury once.		21. Signature of Funeral Service License	Charri			uneral Home		providend 21226	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	Chro				onan disen	Approximate Interval Between Onset and Death
8760,		al Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (of as a consequer						
P.O. Box 687	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnance 1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pregnan Other <i>(specify)</i>	ісу		23d. Date of de Month	livery Day Year
	w requires that been signed b should be dete	þ	Part II. Other significant conditions con	ntributing to death but not resulting	ng in the ur	derlying cause o	given in Part I.	1	obacco use contribute to	o the cause of death?
of Vital Records,		Completed	ASCVD					24a. Was auto perfo 1  Yes		utopsy findings available completion of cause of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				ath Check onl	one	
ou of	Phys this	ıtlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	i □ Inpatient 2 □ EH	VOutpatien 3b. Time of Injury	28c. Inj	ther: 4 Nursing I ury at ork? Yes 2 No		dence 6 □Other (Spe how injury occurred	cify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre			28f. Location ( City or Tot	Street and Number or Ri wn, State)	ural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direc completely filled in by	edical (	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knowle nar: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	s stated. s to the cause(s)
	To th withir To th comp	Σ	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mont	h, Day, Year)
}			- Ksalv	D MU		Dy	5904		12-6-06	
	10		30. Name and address of person who co	mpleted cause of death (Item 23	3a) (Type, I	Print) Belai	rRd F	Baltir	note MD	21236
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 8 2004	32. Registrar's Signature	G	hora V.				

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

SINA ROSPITAL OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SPI John

32. Registrar's Signature

ANISC

31. Date filed (Month, Day, Year)

DEC 0 8 2004

State Registrar

DEC 0 8 2004

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The sale of Confidential M.D. III Penn Street, Baltimore, Maryland 21201

ORIGINAL PORTS

			1 - For State Registrar		artment of Health and M rtificate of Death	Mental Hygie Reg	ZUU	4 388	29
	Physic	ian	Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of	Death
	/Medi		John	Trotter		December		9:55	a <sup>M</sup>
1	Examir	ner	4a. Facility Name (If not institution, give stree	t and number)	4b. City, Town, or Location of Death		4c. County o	f Death	
			190 Old River Road		Arnold		Anne A	Arundel	
	Funeral		5. Social Security Number 6. Sex 1219-01-8082	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear)	<ol> <li>Birthplace (State or Country)</li> </ol>	r Foreign
	Director		Usual Residence of Decedent	93 Yrs.		April 9,	1911	Maryland	
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside Cit	y Limits
	Man Man	to	MD Anne Arund	el Arnold				1 ☐ Yes	<b>2</b> ₹XNo
	h the	irec	10e. Street and Number		10f. Zip Code	10g	Citizen of Wi	nat Country?	
	th will	alD	190 Old River Road		21012		USA		
	ems ems	Funeral Director	11. Marital Status 12. V	/as Decedent Ever in U.S. 13. med Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		- American Indian,	
36	or it	y Fu	1 Never Married 2 Married 1	XYes 2 □ No	1 ☐ Yes 2 🖾 No Specify:	rican, etc.)	Specify:	, White, etc. White	
21215-0036	within 72 hours after death with the Maryland ene. then "neturet", or items 23e or 28e-f show the Medical Examinat must be notified at	d by	3 A Widowed 4 Divorced Y	ear or Dates: WWLL			Specify:	WILLE	
5	"net	Completed	15. Decedent's Education (Specify only highest grade con	npleted) (Give	dent's Usual Occupation kind of work done during most of work	ing 16	o. Kind of Bus	iness/Industry	
12	withii ene. then	g m	Elementary/Secondary (0-12) C	ollege (1-4or 5+) Pilot	DO NOT use retired)	D			
	filled Hygi ther	ပို	17. Father's Name (First, Middle, Last)	LIIO		e (First, Middle, Mai	ewery	1	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other then "neture!", or items 23e or 28e-f show other treumatic event, I're Medical Examinal must be notified at	To Be	John R. Trotter			huchardt	uen Sumame,	,	
<u></u>	shoul nd Ma marl	F	19a. Informant's Name/Relationship (Type, P	Print) 19b. Mailir	ng Address (Street and Number or Run		ity or Town S	tate 7in Code)	
M	and 2 saith ai n 27 is		Elizabeth T. Rucker		Ridgeway E., Arn			ate, 210 000e)	
ē,	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition	20b. Place of Dispo	sition (Name of			ity or Town, State	
E O	e = 5	(1)	1XXBurial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	vai irom State	vet. Cem. 12-7	-2004 C	***	411 - MD	
Baltimore,	구두만구	- 1	21. Signature of Funeral Service Licensee	11 1	. Name and Address of Facility			ille, MD	
ä	Depar Impor eny ir	(V )	Valach A (1	edd 1	Hardesty Funeral 12 Ridgely Avenue	Home, P.A	· - 100	21/01	
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	ns that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,	LS	Approximate	
	Physician :		Immediate Cause (Final disease or condition	Co. 1	- 01			Interval Betwo	een eath
	/Medical		resulting in death)	Due to (or as a consequence of):	Sufficiency		-		
В	Examiner		Sequentially list conditions	I Schemic C	and omeron the	~			
	P ≓	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	July 1	0			
	ecute and trans	Examine	Cause (Disease or injury that initiated events c	Coronary art	en disease a	rd myoca	dial		
8760,	cate be executed physician and the burial-transit		is a second seco	Due to (or as a configuence of):	0	od myoca	tion		
87	cate phys the	dical	d						
× 6	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/Me	IF FEMALE:	yes, outcome of pregnancy	400			(	
Вох	atten for u	cian	in the past 12 months?	Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of Month		ar
0	that the de led by the a detached	ysic		Unknown	Other (specify)			,	
٩	that led by deta		Part II. Other significant conditions contribut	ing to death but not resulting in the ur	iderlying cause given in Part I.	23e. Did tobaco	o use contrib	ute to the cause of dea	ath?
Sp.	uires I sign Id be	d by	Hypertension			1 🗷 Yes		☐ Probably 4 ☐Un	
00	w requ	lete	0 - 21	A		24a. Was an			
Vital Records,	The lay ate has page 2	ompleted	Jest paem	.0		autopsy performed	I'! Dric	re autopsy findings av or to completion of cau	railable use of
la		e Cc	25. Was case referred to medical			1  Yes 2		Yes 2□ No	
	Sic Se	o Be	examiner?  1 Yes 2 No Hospita	al: 1  Inpatient 2 ER/Outpatien	26. Place of Death				- 727
of		F- 4		a. Date of Injury (Month, Day Year)  (Month, Day Year)  (Month, Day Year)	4 Nursing Hol	me 5 esidence 28d. Describe how in			
on	부 - 폭호	tio	1 ☐ Aatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,		
Division	l or Attendi after death. Director: A in by the fu	ifica	3 Suicide 6 Could not be	Place of Injury - At home, farm, stre	eet, factory, office	28f. Location (Street	and Number	or Rural Route Numbe	er,
Ö	s after of Director	Certification:	4   Hollicide	building, etc. (Specify)		City or Town, St	ate)		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	7	29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: C	To the best of my knowledge, death	occurred at the time, date and place, a	and due to the cause	(s) and mann	er as stated.	
	the H in 24 the F iplete	ledica	a a	nd manner stated.	estigation, in my opinion, death occurre	ed at the time, date :	and place, and	due to the cause(s)	
,	To with	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (/	Month, Day, Year)	
ŧ	18		phatore S. L.	auna, MD	D41034	Dec	ember 3	2004	
	1.0		30. Name and address of person who complet					/	
				128 LUBRANO DRI	VE SUITE 300 A	NNAPOLIS	I MO	21401	
	Sta Registra		31. Date filed (Month, Day, Year) <b>NFC. 0 8</b> 2004	32. Registrar's Signature	Soorte!				
-			115.6 0 0 2009	90	Jan Grand				

12/4/04 Tome, charles 1538

			epartment of Health and N Certificate of Death		iege 004 38830
Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	
/Media	cal	CHARLES R. TOME  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4, 2004   3:38 p <sup>M</sup>
Examir	ier	Harford Memorial Hospital	Havre de Gra		4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe		8. Date of Birth	Harford  9. Birthplace (State or Foreign
Director		213-46-0750 125M 2 F 59 Yr	s. Violatis Days Flours Mill.	Month Day 11/18	/45 Maryland
land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	r Location		10d. fnside City Limits
Many R-f sh	io	MD Cecil Pe	erryville		1X Yes 2 □ No
ith the	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country?
death with the Maryland ms 23a or 28a-f show triust be notified at		26 Collins Drive  11. Marital Status 12. Was Decedent Ever in U.S.	21903		United States
ife, IMBIVIBILG Z IZID-DUSO s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "netural; or items 23e or 28e-1 show other traumatic event, the Medical Exertities must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No  If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp ff Yes, specify Cuban, Mexican, Puerto 1 Yes 2 KNo Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
72 ho	sted		ecedent's Usual Occupation ive kind of work done during most of work	kina	16b. Kind of Business/Industry
Mithin Ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)	ung .	14
nd ZIZIO-1 e filed within 72 h al Hygiene. I other then "netu vsnt, I're Medica		1 O  17. Father's Name (First, Middle, Last)	Dairy Farmer	e (First, Middle, M	Farming  Maiden Sumame)
land lid be file lental Hy kad oth ic evsni	To Be	Christopher D. Tome		B. Gro	
Maryland d 2 should be f th and Mental H 7 is marked of traumatic evs.	-	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rur	ral Route Number,	City or Town, State, Zip Code)
e, M 1 and 2 Health 1 m 27 l			Collins Drive,	-	
O 8° = 5		1 Burial 2 Cremation 3 Removal from State	sposition (Name of crematory or other place) rgers Chapel 12,		Red Lion, PA
Daltim permit. Page Department Important: any injury once.		21. Signature of Funeral Service Licensee Twelvelor	22. Name and Address of Facility  Harkins Funeral		
		23a. Pany Enter he disease, or complications that caused the death. On not	enter the mode of dying, such as cardiac	or respiratory arre	Interval Between
Physician		Immédiate Cause (Final disease or condition resulting in death)	railar acc	clent	Onset and Death
/Medical Examiner		Due to (grasa consequence of)	mt. Cardin	asul di	2
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	TO WE CONSCIO	do	Zoase
ocuted nd transit	Examiner	that initiated events C.			7CF - C.
of ou,		resulting in death) Last Due to (or as a consequence of):			
icate be e	dical	d.			
ox overtiff	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
death death	sicia	in the past 12 months?  1  Yes 2 No  1  Yes 2 No	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
at the d by th	Phys	9 🗆 Onknown			
w requires the been signer should be d	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underfying cause given in Part I.		accoluse contribute to the cause of death ss
i vital necolus, F.O. BOX o visition: The law requires that the death certific is certificate has been signed by the attending director, page 2 should be detached for use as	Completed			24a. Was an autopsy perform 1 Yes	prior to completion of cause of
VIIC	Be	25. Was case referred to medical examinar?		h Check onl one	
ding Phys	: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	me 5 Resider 28d. Describe hov	nce 6 Other (Specify)
nding ath. r: Afte	atior	1 Dvatural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation			.,.,
al or Atta s after dea al Diracto	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Pface of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours affect death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, r investigation, in my opinion, death occurr	and due to the cau	use(s) and manner as stated. te and place, and due to the cause(s)
	M	29b. Signature and title of certifier  M 1	29c. License number	29	d. Date signed (Month. Day, Year)
7		30. Name and address of person who completed cause of death (ftem 23a) (Ty	De, Print)	170- /	1600
	<b>.</b>	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	seawon SY Wa	NIE OL	eurace MV
Sta Registr		DEC 0 8 2004 Arsua 19	Sparks		21015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items of Maryland Department of the dry and Bally geno 4 you 38831 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Wilson Gerald 1225 N 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland NIA Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 05 · 1 ( -5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **M** M 2 □ F 212.58.7276 Yrs. MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Madical Exempter and be notified at 1 XYes 2 No Director MD N BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 1028 ELLICOTI DRIVE USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INSPECTOR GED NIA 17. Father's Name (First, Middle, Last) Gerald M. 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is marked of Wilson EDNA WILSON 19a. Interment's Name/Relations in (Type Print), Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. 1028 ELLICOT BALTO 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State BALTO MO GREENMOUNT ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CREMATION SERVICES 5151 BAUTO NATU PIKE, BALTO. MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bacterial endocarditis Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mjury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No \*Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Ana S Fuentes 11/29/04

Registrar

State

South Greene

32. Registrar's Signature

Street Baltimore MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S Frentes

DEC 0 8 2004

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 10e per fh 9838 12-8-04 yt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rache Williams 5 CCAM 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Health Baltimore atousville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Days Hours 219.26.969 1 □ M 2 🖫 F 96rs. Director 10.10.1908 MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 7 le marked other then "neturel", or Iteme 23a or 28a-f show traumatic event, Ira Medical Examinar must be notified at 10d. Inside City Limits NIA MD Baltimore Director 1 XYes 2 □ No 704 Brookwood Rd. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 21229 U.S.A. Funeral death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 8th grade HOUSEKEEPER NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Milbum Charles Rachel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard M. Green/son 704 Brookwood Road Baltimore MD 21229 other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State injury or 12.10.04 ZION Baltimore, MD MT. \* 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departm
Importe
any inju 21. Signative of Funera Service Lice 22. Name and Address of Facility VALIGHT C. GREENE FUNERAL SERVICES Jane 5151 Baitimore National Pike Balto. MD 21229 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final THE ROSCLEROTIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, beauing to link, ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Box 68760, the attending physician thed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) Records, P.O. detached 9 Unknown Part 4L Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods MELLITERS 1 Yes 2 No 3 Probably 4 Øbhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 201No ital 1 ☐ Yes 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 2 in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Director: After Certification: Division Injury 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel D the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Uhami suchen 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Pripe ASNEEM AKHAN 7220 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 8 2004

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Year Decembe 205 **Physician** 2006 /Medical 4c. County of Death Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Augsburg 5. Social Security Number 248-58-598 HUnder 24 Hrs. 8. Date Nursuna 7. Age (In yrs. lest birthday, 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2MF Director Usuel Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location traumatic event, the Madical Examiner must be notified a 1 TYes 2 □ No Funeral Director Herns 23a or 28a-f 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexicen, Puerto Rican, etc.) 14. Race American tndian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☑ Married 2 No 5 1 Yes 2 No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) pernit. Pages 1 and 2 should be filed within 72 h Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "nati ntary/Secondary (0-12) College (1-4or 5+) CHEF Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Freeman Allen treeman IDAN 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Nu ver, City or Town, State, Zip Code) INUSON-Brow other 20b. Place of Disposition (Name of 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - Olly or Town, State any injury or Greene Fundin 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility KandallStrum, MD 28 23a. Part1. Enter the inseese, or complications that caused the death. Do not enter the mode of dying, such as or reliac or respiratory arrest shock, or he in collure. List only one cause on each line. Approximete Intervat Between **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Physiclan/Medical Examiner or Attending Physicisn: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): resulting in death) Last After this certificata has been signed by the a funeral director, page 2 should be datached it Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? ≥√ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 000 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Nursing Home Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1/ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a, Certifier (Check only one) prtifying Physicisn: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical 29b. Signature end title of Partifier 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar HARBL

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8 2004

32. Registrer's Signature

			1 - State Registrar	State of Maryland		artment of H			ene 004	38834
	Physic		1. Decedent's Name (First, Middle, Last  AMELIA	WATERS				2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give Howard County Ger	street and number)		4b. City, Town, or Columbia		12111	4c. County of Dea Howard	7
	Funeral Director		5. Social Security Number 6. Se 216-20-0660	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 4,	Year) 9. Bir 1927 Man	thplace (State or Foreign ounty) Cyland
	tiled within 72 hours after death with the Maryland Hygiene. uther than "natural", or tlems 23a or 28a-1 ehow ont, the Medical Exartifical usable radiified at	ector	10a. State 10b. County  Maryland Baltimon	10c. City, T	own or Lo	ne				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eath with the 23a or 2	Funeral Director	10e. Street and Number 2723 Norfen Rd.	12. Was Decedent Ever in U.S.	12.1	10f. Zip Code 21227	Odeina (G		U. S. A.	<u> </u>
980	ours after d ral', or Item Examinat	þ	11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 N No If Yes, Give Year or Dates:		Vas Decedent of His f Yes, specify Cubar I ☐ Yes 2🌠 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	be filed within 72 hours after death with the Marylan nat Hygiene. od other than "natural", or Items 23a or 28a-f ehow event, the Medical Examilant mat be traffied at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give life. [	lent's Usual Occupa kind of work done do DO NOT use retired)	uring most of work	ing 1	6b. Kind of Business	•
Maryland 2	a la b	To Be Co	12 17. Father's Name (First, Middle, Last) Harry Joseph Holl		ritte	Research	18. Mother's Nam	e (First, Middle, M nnie McA		Titles
_	es 1 and 2 should be for Health and Mental I item 27 is marked of rother traumatic eve	188	19a. Informant's Name/Relationship (Ty James Waters, hus	band	2723	Norfen R			City or Town, State, 2	Zíp Code)
Baltimore,	permit. Pages 1 a Department of He Important: If item any injury or othe		20a. Method of Disposition 1 □ Maurial 2 □ Cremation 3 □ F 1 □ Onation 5 □ Other (Specify)	emoval from State Glen	Have		l Park 1	2-10-04	0c. Location - City or Glen Burn	
Bal	permii Depar Impor any in		21. Signature of Funeral Service Licens  23a. Part1. Enter the disease, or compl	Per-		Name and Address Ambrose F 2719 Hamm	onds Fer	ry Rd. La	ansdowne,	
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	ter		nnen		51,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter U John you Cause (Disease or Injury	Due to (or as a consequent		,				
8760,	cate be executed ohysician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):					
.O. Box 6	the death certification of the attending of the deferuse as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dec 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other ( <i>specify)</i>			23d. Date of deli Month	very Day Year
ords, P	w requires that been signed by should be deta	by	Part II. Other significant conditions cor	tributing to death but not resulting	g in the un	derlying cause giver	n in Part I.		acco use contribute to	the cause of death?
at Reco	The lay ate has page 2	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
Division of Vitat Records,	ding Physician: Th th. After this certificate funeral director, pag	tlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Outpatient o. Time of Injury	3 DOA Other 28c. Injury a Work?	4 Nursing Ho	n <i>(Check only one)</i> me 5 Residen 28d. Describe how	ce 6 □Other (Spec	ify)
Divisi	tal or Attending s after death. al Director: After ed in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre			28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	one)	icien: To the best of my knowled ter: On the basis of examination and manner stated	and/or inv	estigation, in my opi	nion, death occurr	ed at the time, date	e and place, and due	to the cause(s)
ł	T with	4		AUMOUD ND	-	29c. License	number 25	290	1. Date signed (Month	MODIFA
	Sta	to	30. Name and address of person who co TAZIQ MACM 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a 20(-/C) 32. Registrar's Signature	a) (Type, F	Back R	ive Ne	iknd	Baltin	40 1112/ ere
	Registr		DEC 0 8 2004	Le mas A	g g	contro				

State of Maryland / Department of Health and Mental Hygiene 38835 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 December 4, 7:05am M Anne Wilson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner 7426 Village Road Unit 313 Svkesville Carrol1 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs Director 215-58-8112 81 March 17, 1923 Scotland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 77 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1♥ Yes 2 No Director MD Carrol1 Svkesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 7426 Village Road Unit 313 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I importent: if item 27 is marked other than "natural", or item any injury or other treumatic event. It a Medical Exercises and any injury or other treumatic event. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurses Aide Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peter Smith Margaret Meichan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Wilson (Son) 2001 Sherlock Holmes St., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gate of Heaven Cemeterv12/7/04 Silver Spring, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOME & CHAPEL, P.A. (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that c used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause only a line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician anspr disease or condition resulting in death) Man /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 20240 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 ☐ Yes 2 ₩No 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it commatately filled in by the funera 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of perfitie MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner Wilber Kuo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 8 2004

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar		State of	Marylaı	nd / Depa	artment rtificate					Reg. No.	004	388	
	Physici	an	1. Decedent's Name (First, Mic	idle, Last)				_				2. Date of Dea Month	Day	Year	3. Time of	
	/Medic		Dinah		rossma		Wo	lfe			1	Decembe		2004		a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institu					4b. City, T			of Death			ounty of Dea		
			Anne Arunde 1  5. Social Security Number	Medi 6. Sex			. last birthday)	Ann If Under 1	napo.	L1S If Under	24 Hrs.	8. Date of Birt		ne Aru		r Foreign
	Funeral Director		227-01-7718  Usual Residence of Decedent		M 2 <b>X</b> )F	96	Yrs.		Days	Hours	Min.	Aug 25	1 <sup>908</sup>	Mar	thplace (State of ountry) yland	r i oreign
	land w		10a. State 10b. Cou	nty		10c. C	ity, Town or Lo	cation							10d. Inside Cit	ty Limits
	Mary f sh	호	MD An	ne Arı	undel		Annapo	olis							1 <b>∑</b> Yes	2 🗆 No
	r 28a	Director	10e. Street and Number					10f. Zip (	Code				10g. Citize	n of What C	ountry?	
	h witi	ai D	308 Giddings	Avent	ıe			2	1401				U	SA		
	deal	Funerai	11, Marital Status	13	2. Was Deced		J.S. 13.	Was Decede	ent of His	panic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	. 14	Race - Am Black, Wh	erican Indian, ite. etc.	
9	or it		1 Never Married 2 N		1 ☐ Yes 2 If Yes, Give	. Mo		1 □ Yes 2		Specify:			Sı	pecify:	White	
8	hours urai',	d by	3 X Widowed 4 □ Divord	ed lent's Educa	Year or Dat	es:	162 Doco	dent's Usual	Occupa	tion		-	16h Kind	of Business	/Industry	
15	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show Ita Medical Examii etrinust be inciffied at	jete	(Specify only hig	hest grade	completed)		(Give	kind of work	k done du	uring mos	t of workir	ng	TOD, KING	OI BUSINESS	villoustry	
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D	e filed al Hygie other vent, il	BeC	17. Father's Name (First, Midd	le, Last)			,			18. Mothe	r's Name	(First, Middle,		_		
<u>lan</u>	Aental rked o	To B	Jacob Grossm	an						C1	ara k	Kramer				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Medical Examilier must be notified at	,-	19a. Informant's Name/Relation	nship (Typ	e, Print)							Route Numbe				
	1 and 2 Heelth tem 27 i		Joyce W. Hof	fer (	Daught					Avenu	and the second	nnapoli				
ore	of Hi of Hi if iter		20a. Method of Disposition 1 X Burial 2 ☐ Crematic	n 3∐Re	moval from St	1	Place of Dispo cemetery, crei	natory or oth	e of her place			ate		_	Town, State	
Ë	Pag tment tant: Jury		`4 □Donation 5 □Other	(Specify)		Ве	th-El				.2/5/			nond,	VA	
Baltimore,	permit. Pages 1 Department of H Important: if ite any injury or ot once.	n Si I	21. Signature of Funeral Servi	Ha	yleity			12 Ri	Ldge.	ly Av	renue	Home, I , Annap	olis,	, MD 2	1401	
100	Physician /Medical Examiner		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	or complic ist only one	cause on etail	used the dea ch line. PG r as a conse	Failur		of dying	, such as	cardiac o	respiratory ar	rest,		Approximate Interval Betwoen Conset and D	ween Death
68760,		Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c.	Due to (or	r as a conse										
P.O. Box 68	death certifica e attending ph ed for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23		th 2 ☐ Fet nt at time of	al death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>					230	d. Date of de Month	*	'ear
	luires that n signed t	by	Part II. Other significant cond	litions cont	ributing to dea	ith but not re	sulting in the u	nderlying ca	use give	n in Part I.			obacco use (es 2 🗆 I		o the cause of di robably 4月0	
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>		0 8	examiner? 1 ☐ Yes 2 ☑ No	Ho	spital: 12 In	patient 2	ER/Outpatier	nt 3 DO	Othe	r: 4□Nu	rsing Hon	ne 5 🗆 Resid	lence 6 [	Other (Spe	əcify)	
on of	ding After fune	tion; T	27. Manner of Death  1 Natural 5 Per 2 Accident	ding stigation	28a. Date of (Month)	Injury , Day Year)	28b. Time o Injury	f 28	c. Injury Work		2	8d. Describe h				
Division	5 # 5 ⊆	Certification;	3 ☐ Suicide 6 ☐ Cou	ld not be mined	28e. Place o building	of Injury - At I g, etc. (Spec	nome, farm, str ify)	reet, factory,	office		2	Bf. Location (S City or Tox		Number or F	ural Route Numi	ber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C				sis of examin	owledge, deat ation and/or in								s stated. e to the cause(s)	)
	To th To th compl	Me	29b. Signature and title of cert	ifier				29c.	License	number	,		29d. Date s	signed (Mon	th, Day, Year)	-
)	1		> Y/L v	/- A	N			Y	100	513	01	6	Dece !	M601	3,200	/
	3,		30-Name and address of pers	on who con		of death (Ite	m 23a) (Type,	Print)	ale	300	Av	inapoli:	5 M	0 2	3, 200 401	
	Sta Registi		31. Date filed (Month, Day, Ye	0 8 20	32. Re	gistrar's Sign	ature	1 4	oak	1/2/		,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 2004 Physician 1:30 Α. Wilson Joseph ·/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie North Arundel Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) 0Ct. 2 1956 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min Hours MD 1 X M 2 □ F Yrs. 48 Director 220-68-5063 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28e-f show any injury or other fraumatic event, the Medical Event art must be rediffied at once. 1 ☐ Yes 2 ☑ No Pasadena Director Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 1219 Hillside Road Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Fisherman 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Link Irene Wilson Douglas D. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1219 Hillside Road, Pasadena, MD 21122 Margaret Blevins (spouse) Date 07 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 2004 Metro Crematory Inc. `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur of Funeral Service Stallings Funeral Home, P.A. 3111 Mountain Rd. Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final obstructive disease Physician monte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Omo Kalenna that initiated events resulting in death) Last Due to (or as a consequence of) Drabetes Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No Ö the 9 Unknown ģ ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to à Division of Vital Records, Hegatitis 3 Probably 4 Unknown 2 🗌 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check on one director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 ihis 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death

Natural

Accident 28b. Time of After t Certification: or Attending Injury 5 Pending investigation 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Diractor: All completely filled in by the fu 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗀 Suicide determined filled in by 4 🗌 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Physrzian 000,56950 December 7, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raynor Blud Suite A Pasadena MD 21122 Agajelu 32 Edwin 8094 Nnaemeka 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1tem#1,17,19a, perfn. MD C838,12/20/04 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)
Lawrence Anthony Waudby, Sr.
Lawrence Anthony Waudby 11:50 PM 2004 November 30, **Physician** Sr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Lorien Frankford Nursing Home 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 6, 1 7. Age (In yrs. last birthday) Social Security Number 6. Sex Days Mary land Months **Funeral )**XXM 2□F 1922 Director 217-18-1044 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ed other than "naturel", or items 23s or 28s-f show event, the Medicul Examinar must be notified at 1 ☐ Yes 2**\**(\)\(\)\(\)\(\)\(\) Abington Harford Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21009 U.S.A. 203 Windmille Pointe #2B Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? MYes 2 □ No fryes, Give WW II Year or Dates: 1 Never Married 2 X Karried Specify: White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) leted 15. Decedent's Education (Specify only highest grade completed) Baltimore Gas Compi College (1-4or 5+) Elementary/Secondary (0-12) & Electric Co Stationary Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) marked other 17. Father's Name (First, Middle, Last) Be Henry Waudby Henry Wauby Pages 1 and 2 should be nent of Health and Mental ent: If item 27 le marked o Studzinski Helen 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna Waudby Anna Wauby / Wifefe Abington, Maryland 21009 #2B 203 Windmille Pointe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 12-3-2004 permit. Page Depertment of Importent: If any injury or once. Oaklawn Cemetery 4 □ Donation 5 □ Other (Specify) Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ASCVD /Medical Due to (or as a consequence of) **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Box 68760 Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 2 X No 26. Place of Death Check onl. one or Attending Physicien: Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐XNo Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1XXVatural 5 Pending 1 🗌 Yes 2 🗌 No investigation after death. 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 6, 2004 ,MD D577271 nd address of person who completed cause of death (ftem 23a) (Type, Print) Essex, Maryland 21221 201-109 Back River Neck Road Narender, M.D 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 8 2004

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

			1- For State of Maryland Registrar	I / Department of Health and N Certificate of Death	Mental Hygier Reg. R	CHUR SERVED
	Physici	an	1. Decedent's Name (First, Middle, Last)	- SENIOR	2. Date of Death	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	11 2	c. County of Death
	Ladiiii		SAVAGE PIVER STATE FOR		REST	Garrett
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	- g		212-46-1010 57  Usual Residence of Decedent		03/16/194	7 Maryland
	death with the Maryland ms 23a or 28a-f show froust be notified at	5		Town or Location		10d. Inside City Limits 1 XYes 2 □ No
	the N	Funeral Director	MD Harford Edg	gewood 10f. Zip Code	100.0	Citizen of What Country?
	h with	ai Di	1986 Chipper Drive	21040	1	SA
	tams :	nner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
39	irs afte	by Fi	1 Never Married 2 Married 2 Married 2 Married 2 Married 1 Never Married 2 Marri	1 ☐ Yes 2 X No Specify:		Specify: White
2-0(	72 hou	eted		16a. Decedent's Usual Occupation	king 16b.	Kind of Business/Industry
121	within ane.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)		
d 2	illed in Hygie	Be Co	GED 17. Father's Name (First, Middle, Last)	Truck Driver	ne (First, Middle, Maide	reight Company
ylan	2 should be filed within 72 hours after dear and Mental Hygiene. Is marked other than "natural", or Itams : aumatic event, the Madical Examinator.	To B	Unknown	Mary Wa	agner	
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at			19b. Mailing Address (Street and Number or Rui		
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Baltimore,	permit. Pages 1 and Department of Health Important; If itam 27 any injury or other tr once.		21. Signature of Funeral Service Licensee	Mitchell-Smith Fune	The second second	
	<u></u> <u> </u>	1	23a. Part 1. Enter the disease, or complications that caused the death.	123 S. Washington,	<u>Havre</u> de	Grace, MD 21078
	Physician and // Medical Examiner stee private and stee private stee private steep the private steep t	Examiner	Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)		any vas	Sease
8760,	ate be e hysiciar the buri	dical E	d			
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	eath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
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il Records,	ding Physician: The law re h. After this certificate has be funeral director, page 2 shc	Completed			24a. Was an autopsy performed? 1 □ Yes 2 € N	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
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Division	tandin leath. tor: Aft the fun	Certification:	2 Accident investigation	M 1 Yes 2 No		
Divi	after of Dirac	ertif	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
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	To the To the comp	ž	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
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	Sta Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sparks		21538

			1 - For State Registrar	State of Ma	arylan		artment rtificate			and M		giene Reg. No.	004	38841
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Anthony E.	Winkle	~						2. Date of De Month	Day 3	2004	3. Time of Death
	Examir	ner	4a. Fecility Name (If not institution, give s BNAMWOOD 51  5. Social Security, Number 6. Sex	5 Brigh	Hfie o (In yrs.	td82d	Luy	Ver I	Location of	24 Hrs.	8. Date of Bir	Bal	ounty of Death Ltinore 9. Birtho	lace (State or Foreign
	Director		2 6 - 28 - 3 4 2 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	M 2□F   8	3	Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month, Da January	<sup>1</sup> 20°192	1	Maryland Od. Inside City Limits
	the Maryling and Application	rector	Maryland Baltimore  10e. Street and Number			y Hall	10f. Zip (	Code				10g. Citize	n of What Coun	1 ☐ Yes 2 No
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21215-0036	2 should be filed within 72 hours and Manial Hygiana. Is marked other then "naturel", raumatic event, the Medical Extra	Completed b	15. Decedent's Educ (Specify only highest grade	Year or Dates: cation completed) College (1-4or 5	+)	(Give	dent's Usual kind of work DO NOT use 1St	k done di	urina most	of worki	ng		of Business/Inc	
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sion of	ftar na		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury		c. Injury		2	8d. Describe h			
Division	itel or Attendli us after daath. rei Director: A llad in by tha fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of triju building, etc	. (Specify						City or Tow	n, State)	lumber or Rural	
	To the Hospitel or within 24 hours after To the Funarei Dire completely filled in b	Medicai	29a. Certifier (Check only one)  1 ☐ Certifying Physic 2 ☐ Medical Examination (Check only one)	er: On the basis of and manner sta	examinati	vledge, death ion and/or inv	estigation, i	t the time n my opi	nion, death	l place, a n occurre	d at the time, o	tate and pla	ace, and due to	the cause(s)
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	Funeral Director			Sex 7. Age (In yrs	s. last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Ebru Arry		y Qoun	lace (State or i	Foreign
	e Maryland 8e-f show	Director	10a. State 10b. County HARLAND		Oity, Town or Lo							1	0d. Inside City	
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5-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ad other then "neturel", or Items 23e or 28e-f show event, the Modical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decede If Yes, specif 1 Yes 2,		spanic Orig n, Mexican, Specify:	gin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		Race - Americ Black, White, of		2n)
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Baltimore,	permit. Pages Department of i Importent: If it any injury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Light	(y)	cemetery, crem	Me	more	e D	ecent ee c	elih 2004 l		laux)	Mingle	teed
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of	ding Physicien: Th h. After this certificate tuneral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient		Other	4 □ Nurs	sing Home	Check only one, 5 ☐ Residen d. Describe how	ce 6 🗆 O			
á	l or Attending after death. Director: After in by the fune	Certification:	1 V Natural 5 Pending investigation 3 Suicide 6 Could not be determined		Injury nome, farm, stre fy)	M eet, factory, o		es 2⊡No		. Location (Stre City or Town,	et and Nuп State)	nber or Rural	Route Number	;
	Hospitel 4 hours Funerel ely filled	edical Ce	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my known inter: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at estigation, ir	the time	, date and nion, death	place, and	I due to the cau at the time, dat	ise(s) and me and place	nanner as sta , and due to t	ted. he cause(s)	- 8
	To the Pwithin 24 To the Complete	Me	29b. Signature and title of certifier	MD		29c. L	icense i	number	o 0		d. Date sign	ed (Month, D	ay, Year)	
	5		30. Name and address of person who susan CHENG THE				N. W	olfe s	STREET	BALTIE	MORE.			ያገ
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	do	On M			•				- 1

	pe	
Division of Vital Records, P.O. Box 68760,	Hospitel or Attending Physicien: The law requires that the death certificate be executed by house that the death certificate be executed	24 hours and weath.  Funerel Director: After this certificate has been signed by the attending physician and
	H Z	E.

			1 - For State Registrer	State o	f Maryland /	Departmen Certificat				-	_	00	04	38843
	Physici	an	1. Decedent's Name <i>(First, Middle, L</i> Gilbert	ast) Harry	Yard					2. Date of De Month Decembe	Da	iy 2	004	3. Time of Death 7:50 PM
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City,	Town, or	Location of	of Death	Decembe			of Death	7.30 1
			Oak Crest Villa			W.11-4		(ville				Ba	ltimo	
	Funeral Director			Sex 1□XM 2□F	7. Age (In yrs. last bi	Yrs. Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Dec. 30	th ly, <i>Year</i> ) 19	17	9. Birthp Coun	place (State or Foreign htry) England
	ith the Maryland or 28e-f show e notified at	Director	10a. State 10b. County  Maryland Balti 10e. Street and Number			vn or Location	Code	(ville			10g. Ci	itizen of V	What Coun	0d. Inside City Limits 1 ☐ Yes 2 ☑ No ntry?
2-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show eny injury or other treumatic event, the Medical Examinal must be notified at once.	by Funeral	7799 Walther Bl 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		edent Ever in U.S. rces? 2 🔯 No /e		dent of Hi cify Cuba	spanic Origin, Mexican Specify:	gin? (Sp	ecify Yes or No Rican, etc.)	-		USA e - Americ ck, White, w: Wh	
0-6171	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's 8 (Specify only highest g. Elementary/Secondary (0-12) 12	rade completed) College (1	1-4or 5+)	Decedent's Usua (Give kind of wo life. DO NOT u	rk doné a se retired,	luring most }					usiness/Ind	
yland z	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Las	t)				18. Mothe		(First, Middle,	Maider			
, Mar	and 2 sho ealth and m 27 is m		Peter B. Yard	(Type, Print)		13131 Wi	lliam	nfiel	d Dr	., Elli	cott	t Cit	ty, M	D 21042
parimore	nit. Pages 1 artment of H ortent: If ite injury or oti		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 I  4 ☐ Donation 5 ☐ Other (Spec  21. Signature of Funeral Service Lice	ify)	State cemete	of Disposition (Nar ory, crematory or o VIEW Ceme 22. Name an	ther place etery	/	Dec. 20	04	Roc	ckled	city or To	
מ	permi Depar Impor eny ir		6 11/1	SET!		3111 1	1ount	ain I	Road	, Pasad	ena.			
	Physician /Medical Examiner		23a. Part1 Enter the disease, or cor shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	_ a	aused the death. Do ach line.	CVA	e of dying	g, such as	cardiac (	or respiratory as	rrest,			Approximate Interval Between Onset and Death
,007	cate be executed  hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence									
O. BOX O	The law requires that the death certific ite has been signed by the attending p bage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live b	come of pregnancy irth 2 Fetal death ant at time of death own	n 3 ⊟Ectopic pr 5 ⊟ Other (sp						23d. Dat Moi	e of delive	ry Day Year
olds, r	iw requires that s been signed by should be deta	by	Part II. Other significant conditions	contributing to de	eath but not resulting i	n the underlying c	ause give	n in Part I.			obacco (		ibute to th	e cause of death?
משט	The taw reate has bee page 2 sho	Completed	<i>&lt;.</i> /	10				<u>-</u> -		24a. Was autop perfo		F	Vere autoporior to con leath?	osy findings available npletion of cause of
A II d	Physicien: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	. /		(Check only o				
	g Physer this eral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date			8c. Injury Work	4 Jul Nul	-	me 5 Residence R				")
	or Attendin fler death. lirector: Aft n by the fun	ertification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determined	on	of Injury - At home, fang, etc. (Specify)	М	1 🗆 Y	es 2□N		28f. Location (S City or Tox	Street an	nd Numbe	er or Rurai	l Route Number,
ב	To the Hospitel or Attending Physicien: The law within 24 burus after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier 1/2 Certifying P (Check only one) 2 Medicel Exe	miner: On the ba	best of my knowledg asis of examination ar ner stated.	e, death occurred nd/or investigation	at the tim in my op	e, date and inion, deat	d place, th occurr	and due to the e	cause(s) date and	) and made place, a	nner as sta and due to	ated. the cause(s)
	To the comp	Me	29b. Signature and title of certified	76	1	(VU) 290	License	number	2		29d. Da	1-1	(Month, E	Day, Year)
	20			cmen 1	the way	(Type, Print)	w.	eth	41	111	M	ku,	lle	Md 21134
	Sta	te	31. Date filed (Month, Day, Year)	2004 32.8	gistrar's Signature	Angeli	1							

Certificate of Death

38844

3. Time of Death

Reg. No.

Location (Street and Number or Rural Route Number City or Town, State)

29d. Date signed (Month, Day, Year)

11/18/04

ST. MICHARIS MID 21663

2. Date of Death

Division of Vital Records, P.O. Box 68760, or Attending Physicien: completely filled in by the funeral After death. after death within 24 hours a

> State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 19 2004

29b. Signature and little of certifier

2 Accident

3 Suicide

29a. Certifier

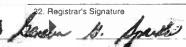
4 Homicide

investigation

6 Could not be determined

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)



alleronly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

PATTERSON MID 8005 TABOTST.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOU 57908

			1 - For State Registrar	State of Maryland / Depa	artment of Health and tificate of Death	Mental Hygie	
	a .		1. Decedent's Name (First, Middle, Last,			2. Date of Death	3. Time of Death
	Physici		Harry E. Araden	Jr.		November	Day Year 1/39 M
	/Medic Examir		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Death
1			MEMORIAL	HOSPITAL	ENSTON		TALBOT
	Funeral		5. Social Security Number 6. Sec		If Under 1 Year If Under 24 Hr Months Days Hours Mir	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		140-20-0092	M 2□F 78 Yrs.		1 1 - 3 - 1 9 2	New Jersey
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	Manyl f sho	0	MD Talbot	Wittman			1 ☐ Yes 2 ☐ No
	the 1	rect	10e. Street and Number		10f. Zip Code	10a	. Citizen of What Country?
	3a or	i D	8699 Tilghman 1	sland Rd	21676		JSA
	death ms 2	Funeral Director			Vas Decedent of Hispanic Origin? ( f Yes, specify Cuban, Mexican, Pue		14. Race - American Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Medical Expriser, just be a chilled at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 TyYes 2 □ No	r Yes, specify Cuban, Mexican, Pue I □ Yes 2🎇 No <i>Specify:</i>	rto Rican, etc.)	Black, White, etc.  Specify: White
Õ	2 ho	Completed	15. Decedent's Edu	cation 16a, Deced	lent's Usual Occupation	168	b. Kind of Business/Industry
218	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of w OO NOT use retired)	orking	
21	filed withi Hygiene. other than	20	12 years		net maker	se	elf employed
nd	d oth	Be	17. Father's Name (First, Middle, Last)	7	18. Mother's Na	ame (First, Middle, Mai	den Sumame)
yla	should be nd Mental r marked o umatic eve	ပ	Harry E. Arader		Anna	Pancoast	
Maryland	2 sho		19a. Informant's Name/Relationship (Ty		g Address (Street and Number or F	·	
	Health tem 27		Aileen Arader (	20b. Place of Dispos	Tilghman Is.		
Baltimore,	Page nent c int: If		1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	cemetery, cren	Crematory 111-		c. Location - City or Town, State
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	Markey. F	Name and Address of Facility Carroll Hur		
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do not enter	er the mode of dying, such as cardia	St. Micha ac or respiratory arrest,	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	A cute Carek  Due to (or as a consequence of):	wal Hemon	rhage	Onset and Death
		ner	Sequentially list conditions, if any leading to immediate	Due to (or as a consiguence of):			
	cate be executed physician and the burial-transit	Examiner	any Lacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				W.
o,	an ar		resulting in death) Last	Due to (or as a consequence of):			
38760,	ate be hysic the bu	dical					
-		Mec	IF FEMALE:				
.O. Box	at the death certific by the attending p tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ds, P	ires tha signed d be de	by	Part II. Other significant conditions con	tributing to death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the cause of death?
Record	w requ been shoul	Completed					
Rec	has ge 2	mp				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
a			22 11			1 ☐ Yes 2 🖸	
Vital		o Be	25. Was case referred to medical examiner?	ospital:	Other	eath (Check only one)	
of		$\vdash$	1 Yes 2 No	1 ER/Outpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time of	28c. Injury at	Home 5 Residence 28d. Describe how in	e 6 □Other (Specify)
O	ding I th. : After : funer	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	Attending r death, ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, stre		28f. Location (Street	t and Number or Rural Route Number,
ā	- 9 -	Certification:	4  Homicide	building, etc. (Specify)		City or Town, S	tate)
	To the Hospital of within 24 hours after the Funeral Discompletely filled in	edical (	29a. Certifier Secretifying Physics (Check only one)	ician: To the best of my knowledge, death ter: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	^	29c. License number	29d.	Date signed (Month, Day, Year)
)			Donnis	De Alandal	0005311	6	117/2004
•			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, I			11/2007
		2	Dennis DeShield			ton, Md.	21601
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	45		
1	Registr	ar	NUV IS 2004	Siece D. Spark			
DH	MH 17 Rev 1/2	001					

ORIGINAL

			1 - For State Registrar	tate of Maryla	nd / Depa <i>Cer</i>	artment of H tificate of L	ealth and M Death		eme 0 0 4	38846
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Į.	Antho:	1		2. Date of Death Month	Day Ye	3. Time of Death
	Examir		4a. Facility Name (If not institution, give stre Holy Cross Hospit			Silver			4c. County of i	
	Funeral Director		5. Social Security Number 051-18-5358  Usual Residence of Decedent	7. Age (In yrs	s. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 26,	1925 Vi	Birthplace (State or Foreign Country) rgin Islands
	Maryland f show	tor	10a. State 10b. County  Maryland Montgomer	_	city, Town or Lo Sethesda					10d. Inside City Limits 11☑Yes 2☐No
	with the I a or 28a- be notif	Director	10e. Street and Number	o+ Ap+ #10	13	10f. Zip Code 20814	<u>,,,,,</u>		g. Citizen of Wha	t Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show appringnts of the traumatic avant, Ire Modical Eraciner must be notified at ances.	by Funerai	10.601 Weymouth Stre  11. Marital Status 12.  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces? 12/2 1 Xiyes 2 No/12 If Yes, Give 6/12	9/43 13. V	Vas Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto		14. Race -	American Indian, White, etc. Black
Baltimore, Maryland 21215-0036	d within 72 hou giene. ir than "nature Ir e Madical E	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)		(Give	lent's Usual Occupa kind of work done d DO NOT use retired; Struction	uring most of worki	ng 1	6b. Kind of Busin	,
and	ild be filed lental Hyg ked othe ic avant,	To Be C	17. Father's Name (First, Middle, Last) Henry Anthon, Sr.				18. Mother's Name Maude B		aiden Sumame)	
Mary	is 1 and 2 shou of Health and M itam 27 is mai othar traumat	-	19a. Informant's Name/Relationship ( <i>Type</i> , Rosemarie Anthon	Print) / Wife	19b. Mailin 10601	g Address (Street a Weymout)	nd Number or Rura n St.#103	Bethesd	City or Town, Sta	te, Zip Code) 20814
more,	Pages 1 a ent of Hes nt: If itam y or otha		20a. Method of Disposition 1 反 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State		sition (Name of natory or other place National	9)	30,2004	Oc. Location - City	
Balti	permit. I Departm Importar any inju		21. Signature of Funeral Service Licensee	e MOLORS			s of Eacility Pope Lboro Pik	Funeral e/Forest	Homes,	P.A. 20747
	Physician /Medical Examiner	iner	23a. Part There the disease, or complicate shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	ons that caused the deadause on each line.  Sep\$\$\text{S}\$  Due to (or as a conset)  Due to (or as a conset)	equence of):	er the mode of dying	n, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
x 68760,	The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Medical Examiner	that initiated events resulting in death) Last d.	Due to (or as a conse						
.O. Box	at the death by the atten tached for u	by Physician/Me	in the past 12 months?	1☐Live birth 2☐Fel 4☐Pregnant at time of 9☐Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
<u>α</u>	quires that in signed b uld be deta	ed by Pł	Part II. Other significant conditions contrib	uting to death but not re	sulting in the un	derlying cause give	n in Part I.		_	e to the cause of death?  Probably 4 □Unknown
al Records,		Completed						24a. Was an autopsy performs	prior	e autopsy findings available to completion of cause of h? Yes 2 \( \sum \text{No} \)
of Vital	y s	To Be	25. Was case referred to medical examiner? 1 \( \text{Yes} \) 2\( \text{No} \) No	1 Inpatient 2L	☐ ER/Outpatient	3□ DOA Othe	4   Nursing Hon	ne 5 🗆 Residen	ce 6 Other (	Specify)
Division of	Attanding Physician: sr death. ector: After this certific by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	8a. Date of Injury (Month, Day Year)	28b. Time of Injury		es 2 □No	28d. Describe how		
Ω		Certif	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)			City or Town,	State)	r Rural Route Number,
	To the Hospital or within 24 hours after the Funaral Direction completely filled in I	Medical	29a. Certifier Certifying Physicia (Check only one) Certifying Physicia Certifying Physicia (Check only one)	on the best of my kn On the basis of examin and manner stated.	owledge, death ation and/or inv	estigation, in my opi	inion, death occurre	ed at the time, date	e and place, and	due to the cause(s)
0	T with	~	29b. Signature and title of certifier	MD		29c. License	61390	290	I. Date signed (M	опtn, Day, Year)
_	CIVA		30. Name and address of person who comp			Print)	D	charles	Oh,	40.
•5	Sta Registr		NOV z 4 2004	32. Registrar's Sign	ature					

		For State Registrar	State	of Marylar		rtment of F	lealth and N Death		giene 100 /	38847		
		1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea Month	ith	3. Time of Death		
Physicia /Medic		Calvin Rex All	ison					NOVEMB	BER 14, 2	004 4:40p M		
Examin		4a. Facility Name (If not institution, gi		ımber)		4b. City, Town, o	r Location of Death		4c. County of			
		SUBURBAN HOSPIT	AL			BETHESD	PΑ		MONTGOM	ERY		
Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9	D. Birthplace (State or Foreign		
Director		297-66-0690	1XM 2□ F		43 Yrs.	Widnitis Days	riours wiii.	Jan 30	, 1961 (	Ohio		
P .	[	Usual Residence of Decedent		140: 0:								
aryla show	-	10a. State 10b. County		100. 01	ty, Town or Lo	ation				10d. Inside City Limits		
Be-f.	cto		gomery	B1	urtonsv	_						
or 2	Director	10e. Street and Number				10f. Zîp Code			10g. Citizen of Wha	at Country?		
72 hours after death with the Marylan 72 hours after death with the Marylan *natural; or Items 23a or 28e-1 show palical Examiner must be notified at		3826 Angelton					866		USA			
er de tems	Funeral	11. Marital Status	Armed F	cedent Ever in U	1983 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.		
s afte	by F	1 Never Married 2 Married	If Yes, G	to	1	☐Yes 2XNo	Specify:		Specify:	n 1 1-		
hour		3 ☐ Widowed 4 ☑ Divorced		Dates: 12/19		ent's Usual Occup	ation			Black		
n 72	Completed	15. Decedent's E (Specify only highest gi		)	(Give )	kind of work done	during most of worl	king	16b. Kind of Busin	less/industry		
withi ene. then	E C	Elementary/Secondary (0-12)	College (	(1-4or 5+)		e Techni	•		Compute	r/TV		
titled within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene then "naturel", or Items 23a or 28e-1 show ont, the Madical Examiner must be notified at	e Cc	17. Father's Name (First, Middle, Las			Cabi	.c reciiir		e (First, Middle,	Maiden Sumame)			
d be antal	To Bo	Obin C Allian	_				Marrion	E. Dean				
should be and Mental marked c	F	Otis S. Alliso  19a. Informant's Name/Relationship			19b. Mailin	Address (Street		Maria de la companya de la companya de la companya de la companya de la companya de la companya de la companya	r, City or Town, Sta	ate, Zip Code)		
d 2 s lth ar lth ar 27 is trau		Marrion E. Lus		or		Unity Wa			ОН 4362			
1 and Health tem 27		20a. Method of Disposition	by/Hoth	20b. F	Place of Dispos	ition (Name of			20c. Location - Cit			
Pages nent of I int: If its		1 N Burial 2 □ Cremation 3 i 4 □ Donation 5 □ Other (Spec		1 State		atory or other plac			m - 1 - 1	01. 4		
		21. Signature of Funeral Service Lies		WO	od Lawn	Cemetery Name and Addre	ss of Facility Hin	3/200# 25-Rinal	Toledo, di Funer	onio al Home		
permit. Departimont import		· alan 1	Down	000						ring, MD 20904		
		23a. Part1. Enter the dis ase, or cor	nplications that	caused the deat						Approximate		
		shock, or heart failure. List only Immediate Cause (Final								Interval Between Onset and Death		
Physician /Medical		disease or condition resulting in death)	a	ultip	1 Cu	puries	with co	my 4 CC	etlous			
Examiner			Due to	(or as a consec	(uence or):							
	e.	Sequentially list conditions,	b. — Due to	(or as a soneuc	quenes of):							
uted insit	든	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):							
cate be executed chysician and the burial-transit	dical		. d									
	edle		_ u.									
eath certift attending	Iclan/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		A., . v 1000			23d. Date of	of delivery		
death d for	lcla	in the past 12 months?	4☐ Preg	birth 2 ☐ Feta nant at time of c		Ectopic pregnancy Other (specify)	·		Month	Day Year		
res that the de igned by the a	Physi	9 Unknown	9□ Unkr	nown								
s than	by P	Part II. Other significant conditions	contributing to	death but not res	sulting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?		
quire n sig uld b								1 🗆 Y	es 2 040 3[	☐ Probably 4 ☐ Unknown		
The law requires that the death certification is the law requires that the death certification is the has been signed by the attending page 2 should be detached for use as	Completed							24a. Was a		re autopsy findings available		
The lav te has age 2	mo							autops	med? dea	or to completion of cause of with?  Yes 2 No		
	Ф	25. Was case referred to medical					26. Place of Dea	th (Check only or		165 2 10		
Physicien: this certific	0 8	examiner? 1 XYes 2 No	Hospital: 1 [X	Inpatient 2	ER/Outpatient	3□ DOA Oth	or		ence 6 Other	(Specify)		
등 등 등	L.	27. Manner of Death	28a. Date	of Injury	28b. Time of	A 28c. Injur	y at	28d. Describe ho	ow injury occurred			
ndin Ith.	Certification;	1 Natural 5 Pending 2 Accident investigation	0.0	nth, Day Year)	06:5	/ M 1 □	Yes 2 No	river st	rull by	another car		
Atte r deg actor	ifica	3 Suicide 6 Could not determined	289. Plac	e of Injury - At h	ome, farm, stre	et, factory, office		28f. Location (S	treet and Number	or Bural Route Number Randolp's Rick		
s afte	Sert	4 🗆 Homode	Dulic	ding, etc. ( <i>Speci</i> i	"stre	et		at Laurie	Drive Mou	itgomery County, MD		
pspit hour Inere							ne, date and place,	and due to the c	ause(s) and mann	er as stated.		
To the Hospitel or Attending within 24 hours alter death of the Funeral Director: After completely filled in by the funeral process.	Medical	(Check only 2 Medical Exa	and mar	basis of examina nner stated.	ation and/or inv	estigation, in my o	pinion, death occur	red at the time, d	ate and place, and	d due to the cause(s)		
To the within To the Comp	Σ	29b. Signature and title of certifier				29c. Licens	e number		9d. Date signed (A			
9		· Zabirel	tal,	Ali		OCME		N	OVEMBER .	16, 2004		
0		30. Name and address of person who	completed cau		n 23a) (Type, f	Print)						
		ZABILICA	4 AL	<i>f</i> 111	Penn S	Street, E	Baltimore	, Maryla	nd 21201			
Sta		31. Date filed (Month, Day, Year)	32.1	Registrar's Signa	ature /	0						
Registr	ar	MUV 22	2004	Sepera	P	Spark	2/					

Physicia		Decedent's Name (First, Middle,	TEM #23a&] Last)	b PER PI		14/14	/04 JH 2. Date Mor	of Death	ay Yeer	3. Time of Death
/Medica	al -	40 Equilibrillary (6 and institution	RUT	H G.	ADLER		- ( D - 1)	11	15 2001	
Examine	er	4a. Facility Name (If not institution, Holy Cross Hosp				vn, or Location o r Sprin			c. County of Deat	
uneral		5. Social Security Number 6	6. Sex 7. Ag	e (In yrs. last birtho	Months Da		24 Hrs. 8 Date	of Birth oth, Day, Yea	9 Rin	- <b>y</b> hplace (State or Forei ountry)
irector	-	059-12-7711 Usual Residence of Decedent	1□ M 2□ <b>X</b> F	83 Yrs	5.	110010	Augu	st 27,	1921 Nev	
Wor #		10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limi
pallin Dellin	cto	Maryland Montgo	mery	Bethesd	а					1 X Yes 2 □ N
a or 28a-f show	Funeral Director	10e. Street and Number			10f. Zip Coo 208			10g. C	itizen of What Co USA	untry?
al', or items 23a Examinat must	era	8003 Whittier B	12. Was Decedent	Ever in U.S.			gin? (Specify Yes	or No-	14. Race - Ame	rican Indian
or iter	E E	1 ☐ Never Married 2 ☑ Marrie	Armed Forces?		13. Was Decedent If Yes, specify (			tc.)	Black, Whit	
natural',	d b	3 Widowed 4 Divorced	Year or Dates:		1 □ Yes 2 😾	No Specify:			Specify:	White
	Completed	15. Decedent's (Specify only highest	grade completed)	(G	ecedent's Usual Od Bive kind of work do fe. DO NOT use re	ccupation one during mos	t of working	16b.	Kind of Business/	Industry
thar than	mo o	Elementary/Secondary (0-12)	College (1-4or 5	1+1	ancial Pi				Finance	
	BeC	17. Father's Name (First, Middle, La	ast)			18. Mothe	er's Name (First, )	Middle, Maide	on Sumame)	
narked o	္	Eugene Gratt					ha Fried			
2 4 5		19a. Informant's Name/Relationship Alison Adler- Da			lailing Address (Str					Tip Code) 1, DC 2000
itam 27	Ъ-	20a. Method of Disposition		20b. Place of Di	isposition (Name o	f !	Date		Location - City or	
2 2		14 Burial 2 □ Cremation 3  `4 □ Donation 5 □ Other (Spe		Judean	crematory or other Mem. Gai	rdens 1	1/18/200	4 01	ney, MD	
Important: If its		21. Signature of Funeral Service Li	censee		22. Name and Ad	ddress of Facilit	yHines-R	inaldi	Funeral	Home
SE 5 3		Benara	Ewl		11800 Nev	w Hamps	hire Ave	. Silv		ıg, MD 209
sician ledical aminer		Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):	- a Ma	dying, such as	cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
ledical aminer tisuality	EXa	Immediate Cause (Final disease or condition	a. Due to (or as	PNEUN	LUNG C	GNIET	cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
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DHMH 17 Rev 1/2001

Registrar

NOV 2 2 2004

Meredith Boone    Security   Secu	other than "natural", or items 23e or 28e-f show rent. I're Maxical Extrait ar rotal ke notified at	Completed	(Specify only highest selementary/Secondary (0-12)  12  17. Father's Name (First, Middle, La.	College (1-4or 5+)		amstress	S				nufacture
Section   Sect	marked ot	ă	Meredith Boone	·	19h	Mailing Address	Ber	tha (unk	nown)		in Code)
disease or condition resulting in death)  Sequentially list conditions, fram, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as	Importent: If item 27 I any injury or other tre <u>once.</u>		20a. Method of Disposition  1 XBurial 2 Cremation 3  4 Donation 5 Other (Special Service Lice)	B Removal from State	20b. Place of I cometery Piney F	Disposition (Name, crematory or or or or or or or or or or or or or	me of other place)  Cemetery 1 nd Address of Facility	Date 1/26/04	Litt 1 Wes	le Orlea	ns. MO
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1   Yes 2   No 3   Probably 4   Unk  1   Yes 2   No 3   Probably 4   Unk  24a. Was an autopsy performed performed performed death?  1   Yes 2   No 3   Probably 4   Unk	ohysician and the burial-transit	dical Exa	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a c	consequence of	ot enter the mode f):	de of dying, such as c	ardiac or respirator	y arrest,	NON	Approximate fnterval Between
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			1 - For State Registrar	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. NZ 0 0 4 3885							38851
	Physici		1. Decedent's Name (First, Middle, Las ALANA	ROETTI				2. Date of Dea Month	ath Day	Year 2004	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	CENTER	4b. City, Town, o	Location of Deat	h	4c. County		1000111
	Funeral Director		5. Social Security Number 6. S		n yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		v, Year)	Coun	lace (State or Foreign itry) 1and
	Maryland f show	tor	10a. State 10b. County Maryland Frede		Myersv					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the	lirec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	
	ath wi	rai	3918 Highland	Ave.		21773			United	Stat	es
920	urs after de el', or Iteme Executiver n	by Funeral Director	11. Marital Status  1  Never Married 2  Married 3  Widowed 4  Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2🎇 No	ispanic Origin? (S in, Mexican, Puen Specify:	specify Yes or No- to Rican, etc.)	14. Rad Blad Specify	ce - America ck, White, e	etc.
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther then "neturel", or Iteme 23a or 28e-1 show that the Madicel Examirer must be notified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	rking	16b. Kind of B		
Maryland 2	12 should be filed within h and Mental Hygiene. 7 le marked other than "reumatic event, the Men	Be	17. Father's Name (First, Middle, Last) Charles		Boetti	nger	18. Mother's Nar	me (First, Middle,		<sub>ne)</sub> nzant	
aryl	shoul and Me amark	은	19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street a					
Baltimore, Ma	es 1 and of Healt f Item 2 r other		Charles Boettinge 20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □	Removal from State	Ob. Place of Dispo cemetery, crem	natory or other plac	θ)	Date	20c. Location -	City or Tov	wn, State
Baltin	permit. Pag Department Importent: I any Injury o		* 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen		22	k Cremato Name and Addres 621 Oposs	s of Facility S	tauffer	Funera1	Home	s, P.A.
8760,	Physician and /Medical transit the purial-transit	dical Examiner	23a. Part 1. Enter the disease or companies to the disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a do	seq ence of):	er the mode of dyin  L dy  L hight	g, such as cardiac function	t Sync	olvo me		Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate the has been signed by the attending phy oage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pi 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3 [	Ectopic pregnancy Other (specify)			23d. Dat	te of deliver	ry Day Year
<u>م</u>	quires that n signed b	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did tol			e cause of death?
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	ng Phye fter this neral dir	ToB	examiner?	Hospital: 1 X patient  28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 □ Nursing H	th Check onl on ome 5 Reside	ence 6 Othe		
Division	tal or Attendi s after death. sl Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office		28f. Location (St City or Town	reet and Number, State)	er or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical (	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medicel Exem	rsicien: To the best of my iner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	, and due to the carred at the time, da	ause(s) and ma ate and place, a	nner as sta and due to t	ted. the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier  ASS 157	ATT PROFE	SOR	29c. License	705	2	9d. Date signed	1	ay, Year)
			30. Name and address of person who o	ompleted cause of death 22 S GRE	(Item 23a) (Type, I ENE STA	Print) BAC	TIMORE	. mD 2	21201		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2	32. Registrar's S	Signature	& Se	outs!				

			1 - For Stata Registrar	State of Maryland / [	Department of Health and Certificate of Death	Mental Hygien	-00001
	Dhysisi		1. Decedent's Name (First, Middle, La	st)	2	2. Date of Death Month Da	3. Time of Death
	Physici /Medic		Billie	4.	Bailey		1, 2004 6:20 PM M
	Examir	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Cocation of De		County of Death
	Funeral		Salisbury Nursing 5. Social Security Number 6.5		thday) If Under 1 Year If Under 24 H	rs. 8. Date of Birth	Jicomico  9. Birthplace (State or Foreign
ı.	Director		278-48-5229	M 200F	Yrs. Months Days Hours Mi	n. (Month, Day, Year)	8 Vinginia
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location	1 1/	10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene thar than "natural" or Itams 23a or 28a-1 show int, the Medical Exam or must be positive at	tor	VA. Accor	,	PerAncev	1110	1  Yes 2 □ No
	r 28a-	Funeral Director	10e. Street and Number	THE K TEM	10f. Zip Code	10g. Ci	tizen of What Country?
	th with	al D	10481 LAN	KFORD HAY	23442	2	1. S. A.
	tams	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	rs afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:	, ,	Specify: White
5-0036	2 hour	ted k	15. Decedent's E	ducation 16a.	Decedent's Usual Occupation	16b. K	ind of Business/Industry
215	thin 7: e. en "n Medi	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)	rorking	
2	filed with Hygiene. Ithar than	Con	12+6		SECYETARY		ecveterial
and	ould be fil Mental H arked ott atic evan	Be	17. Father's Name (First, Middle, Last,		41	ame (First, Middle, Maiden	
Maryland	2 should and Men la marke sumatic	은	19a. Informant's Name/Relationship	Time (Brint)	Mailing Address (Street and Number or	H U C	LS TICE
Z	2 6 6		EDWALD The	as a there	12115 ATTANA	ric Rn.	Tem P. VA. 2344
Jre,	of Health of Health fitam 27 r other tr		20a. Method of Disposition	20b. Place of	f Disposition (Name of	Date 20c. Le	ocation - City or Town, State
Ē	Pages nent of I ant: If its ury or o		1,	IRemoval from State  (y)	of crematory or other place)	7/04 WA	HISVILLE, VA.
Baltimore	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	1588	22. Name and Address of Facility	OX KUN	verAll Home
-	<u>0</u> 0 = 0		James n	tat	10481 LANK	FOOD, Hgy.	TEMP. V4 13442
	Fnysician :		Immediate Cause (Final	one cause on each line.	not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a consequence	of):		year-
	Examiner		Sequentially list conditions,	b. Menny	Sin - mik-	SA	mills
	ed tis	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):		
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequence	of):		year-
8760,	cate be ex physician the buria	dlcal E		d			
9		ledic	3-2				
Вох	death certifica e attending pla id for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy	1	23d. Date of delivery
O.		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
۵.	The law requires that the site has been signed by this age 2 should be detache		Part II. Other significant conditions of	contributing to death but not resulting in	the underlying cause given in Part I	23e Did tobacco I	use contribute to the cause of death?
Records,	uires signe	d by	•		the shadiying daddo girdiriir arti.		□ No 3 □ Probably 4 □Unknown
CO	w requi	Completed				24a. Was an	24b. Were autopsy findings available
Re	The tav	ошр				autopsy performed?	prior to completion of cause of death?
Vital		BeC	25. Was case referred to medical examiner?		26. Place of D	1 ☐ Yes 2 ☑ No eath Check on one	1 ☐ Yes 2 ☐ No
of V	ly s	To	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Other: 4 Thrursing	Home 5 Residence	6 □Other (Specify)
n c	ding Ph h. After th funeral	on:	27. Manner of Death 1 Anatural 5 ☐ Pending	(Month, Day Year)	Firme of 28c. Injury at mork?	28d. Describe how injur	y occurred
Division	death death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not b		M 1 Yes 2 No	286 Location (Street on	d Number or Rural Route Number,
Di√	after Direct	Certification;	4 Homicide determined	building, etc. (Specify)	mi, sneet, lactory, office	City or Town, State	) Number of Aural Abble Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Madical Exar	ninar: On the basis of examination and	o, death occurred at the time, date and placed/or investigation, in my opinion, death occ	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)
	ithin 2 o tha	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		e signed (Month, Day, Year)
	F 3 F 8		> month		02950	68 14	1124
-	5MT		30. Name and address of person who	completed cause of death (Item 23a) (	(Type, Print)		0/0/
		18	1 111	obins M.D.		Ave.,Salisb	ury, Md. 21804
	Sta Registr	-	31. Date filed (Month, Day, Year) 7	2004 32. Registrar's Signature	& sparks		

		For	State	of Maryla	and / Dep	artment o	it Healt	n and M	vientai Hy	ygien	8 ~ ~		_
		1 - State Registrar			Ce	rtificate d	of Dea	th		Reg. No	200	ls :	3885
ø° .		1. Decedent's Name (First, Midd	fle, Last)						2. Date of D		٧.		3. Time of De
Physic /Medi		Elizabeth B.	Brittingh	am					Novem	her	15 200	ear	2340
Exami		4a Facility Name (If not institution	on, give street and nu	ımber)	4	4b. City, Tox	vn, or Locati	on of Death			. County of I		
		Keninsua Kee	ional Me	decal	Center	50	Wish	eru		1	Wicon	rue	
Funeral Director		5. Social Security Number 222–30–8689	6. Sex 1 ☐ M 2 ☐ F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 You Months Da		der 24 Hrs.	8. Date of B (Month, D 9-4-19	irth			ce (State or F
3:0:		Usual Residence of Decedent  10a. State 10b. Count	V.	, , , , , ,	City, Town or L	acation			12 , 23				d. Inside City I
"natural", or itams 23a or 28a-f show idical Examiner: sust be notified at	Funeral Director	De. Suss		1.00.	Laurel							100	1 ∐ Yes 🏖
or 28	ire	10e. Street and Number				10f. Zip Cod	de			10g. Ci	tizen of Wha	t Country	y?
23a	a	RD#2 Box 347				1995	6			US	SA		
sms	ner	11. Marital Status	12. Was Dec	edent Ever in	n U.S. 13.	Was Decedent If Yes, specify (	of Hispanic	Origin? (Sp	pecify Yes or N	10-	14. Race - /		
or Itams	F	1 Never Married 2 Ma	rried 1 Yes	2 No		1 ☐ Yes 2 ☐	_		nican, etc.)			White, etc	c.
E	by	3 ☐ Widowed 4 X Divorce	d If Yes, G Year or I	Dates:		TLI Tes 2LA	4NO Spec	эпу:			Specify:	Whit	te
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Is IT	ķ.	19a. Informant's Name/Relation				ng Address (Str						te, Zip C	iode)
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of H If Ita		20a. Method of Disposition 1    Burial 2 □ Cremation	3 □Removal from	State	p. Place of Dispo cemetery, cre-	osition (Name o matory or other	r place)	i	Date	20c. L	ocation - City	y or Town	n, State
ant: ury c		'4 Donation 5 Other (			ld Fello	ws Cem.		11-2	0-04	La	urel,	De.	
Department of Health and Mental Hygiena. Important: If Itam 27 Is marked other than any injury or other traumetic avent, the Manca, injury or other traumetic avent, the Manca.	Ť	21. Signature of Funeral Service	Licensee			2. Name and Ad			- 7/-				100
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25,2004 November н. 4b. City, Town, or Location of Death 4c. County of Death Easton Talbot 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Min. FEB.14,1916 MARYLAND 10d. Inside City Limits 1 ☐ Yes XXNo 10g. Citizen of What Country? 21625 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No Specify: Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry POULTRY GROWER POULTRY 18. Mother's Name (First, Middle, Maiden Sumame) REBECCA MOORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11130 CORDOVA ROAD, CORDOVA, MD 21625 20c. Location - City or Town, State 12-1-2004 CORDOVA, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 23d. Date of delivery Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dilaknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

DENNIS M. DeSHEILDS, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601

32. Registrar's Signature

November 25

2004

the Maryland 28a-f show

Banahart, Nirian

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760 P.0. the ģ Records, cate has l certificate Division of Vital this After

Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1510 NOVember 20,2004 Miriam Mae Banghart /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITALI OF EOSTON Easton Memoriai If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 188-14-3211 1 ☐ M 2 🖫 F 80 3-20-1924 Queens Run, PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. It a Medical Examinal must be muillised an once. MD Talbot St. Michaels 1 Yes ZTNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21663 9529 Ouail Hollow Dr. Apt. 503 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: SpecifyWhite 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hospital 12 years years Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Richard Bowers Annie Packer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John F. Banghart, IV 103 Somerset Ct. Queenstown, Md. 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 11-22-2004 Dover, De. 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 10 me, PC

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Approximately 10 Approximate Interval Between Onset and Death Immediate Cause (Final Myocardiai Infarction Physician Acute disease or condition resulting in death) /Medical Examiner Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physiclan/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funaral Director: A 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier o hupoties D0059487 November 22,2004 ess of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

John Botsis MD 31. Date filed (Month, Day, Year) NOV 23

32 Registrar's Signature

219 S. Washington St., Easton, Md. 21601

			1 - For State of Maryland / Registrar		artment of H			giene 2004	38856
	Physici		Decedent's Name (First, Middle, Last)  Melvin M. Brown				2. Date of Dea Month	22, 2004 Year	3. Time of Death 6:30 A. M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospital Center		4b. City, Town, or			4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 1579–90–6333 1. Sp 1 2 □ F 34	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth Min. (Month, Pay Septembe	(Year) Cou	place (State or Foreign intry) hington, D.C.
	h the Maryland r 28e-f show	Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, To  10c. Street and Number	wn or Lo		Marlbon		10g. Citizen of What Cou	10d. Inside City Limits  Mary Yes 2 □ No  untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any njury or other treumatic event, the Medical Examinar must be notified at anones.	by Funeral	16902 Dery Court  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  16902 Dery Court  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Moo If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	20772 spanic Origin n, Mexican, F Specify:	2 n? (Specify Yes or No- Puerto Rican, etc.)	U.S.A.  14. Race - Amer Black, White Specify: Black	, etc.
Maryland 21215-0036	itled within 72 ho Hygiene. ther then "netur nt, he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2  17. Father's Name (First, Middle, Last)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired, dical. Clerk	luring most o	f working  Name (First, Middle,		ndustry nry Health Serv
/land	uld be f Mental F irked of	To Be	Melvin Bray			TO. MOUTHER'S	Barbara Brow	,	
	nd 2 shouth and Parties and Pa						or Rural Route Number Marlboro, Mar	r, City or Town, State, Zi yland 20772	p Code)
Baltimore,	Pages 1 ar		1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemet	өгу, сгег	osition (Name of matory or other place on Cemetery			20c. Location - City or T	
Balt	permit. Departr Importe any nji		21. Sprature of Funeral Service Licensee					eral Home, Inc , D.C. 20019	
8760,	Physician // Medical Examiner bunial-transit sthe purial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence conseque	of):	o Tensi.		y 5 y .c.	home	Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
О.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying cause give	n in Part I.		bacco use contribute to t	
Vital Records,		e Completed	25. Was case referred to medical			00 Di	24a. Was a autops perform	med? prior to co death? 1 Yes	opsy findings available impletion of cause of
Division of Vi	ding Ph n. After th funeral	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  5 Pending investigation  3 Suicide  6 Could not be determined.	Time of Injury	28c. Injury Work M 1 🗆 Y	r: 4 🗌 Nursii	28d. Describe ho	once 6 Other (Special own injury occurred	
ā	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death	occurred at the time	e, date and p	City or Town	auso(s) and manner as s	itated.
	thin 24 or the Figure 1	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier		ate and place, and due to  9d. Date signed (Month,				
	1 1		ARASTO O YAZdami		29c. License 50 9	154		1	
			30. Name and address of person who completed cause of death (Item 23a)	(Type,	Print)	ORI'NE	MD 20	OVEMber,	
	Sta Registr	3.7	31. Date filed (Month Day Year) 32. Refistrar's NOV Z 4 2004	1					

04-07581 Theodore Barnes

	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
Physici /Media		Theodore Barnes		25, 2004	11:45 A
Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea  6507 Valley Park Road Apartment 4 Seat Pleasa		4c. County of Death	
uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs			George's
irector		237 62 6971 1 May 2 F 61 Yrs. Months Days Hours Min	8. Date of Birth (Month, Day, ) 12 / 13 /	42 Wi	lson,NC
Mo =		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit
r 28a-f ehow notified at	ctor	Md Prince George Seat Pleasant			1¥ Yes 2 ☐ No
23a or 26 sat be no	ai Dire	10e. Street and Number 6507 Valley Park Road #4 10f. Zip Code 20746	109	g. Citizen of What Cou USA	ntry?
ral', or Items 23a or Examiner must be	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? In known  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 No Specify:  1 Nover Married 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White, Specify: B	
"natural", adical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16	6b. Kind of Business/Ir	dustry
than the M	фшо	Elementary/Secondary (0-12) 12th College (1-4or 5+) Mechanic		Private	
Umportant: if them 27 is marked other than "natur any injury or other traumatic event, the Medical ance.	o Be		me <i>(First, Middle, Ma</i> y Willian		
s mar	۲	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R			,
m 27 her tra		Dorothy M. Barnes Sister 4911 Kansas Ave N			
Of a figure		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  1  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cometery, crematory or other place)  Riverdale Crematory 1		oc. Location - City or To Riverdale	
Imports any inju		21. Signature of Funeral Service Licensee Snead Fruncial F	Home& Cre	emation S	ervice
/sician ledical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Cocaine Intoxication Complicating Cardiovascular Disease  Due to (or as a consequence of):	Atheroscle	1	Approximate Interval Between Onset and Death
ledical aminer parial-transit	cai Examiner	shock, or heart faikure. List only one cause on each line.  Immediate Cause (Final disease or condition disease or condition as a. Cardiovascular Disease	ac or respiratory arres Atheroscle	1	Approximate Interval Between
by the attending physician and ached for use as the burial-transit	edicai	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  List only one cause on each line.  Cocaine Intoxication Complicating Cardiovascular Disease  Due to (or as a consequence of):  b.  Due to (or as a consequence of):  Cocaine Intoxication Complicating cardiovascular Disease  Due to (or as a consequence of):	ac or respiratory arres	1	Approximate Interval Between Onset and Death
signed by the attending physician and up of the detached for use as the burial-transit and a second transit and a second transit and the detached for use as the burial-transit and the detached for use as the burial-transit	by Physician/Medical	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  1	Atheroscle  23e. Did toba	t. erotic	Approximate Interval Between Onset and Death Onset and Death
has been signed by the attending physician and injury of 2 should be detached for use as the burial-transit in a large.	Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown  23c. If yes, outcome of death 5 Other (specify) 9 Unknown  23d. If yes, outcome of death 5 Other (specify) 9 Unknown  23d. If yes, outcome of death 5 Other (specify) 9 Unknown	23e. Did toba  1  Yes  24a. Was an autopsy performe	23d. Date of deliver Month  22 No 3 Protection Prior to co	Approximate Interval Between Onset and Death Onset and Death Death Pay Year Day Year Dably 4 Nnknow
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State of Maryland / Department of Health and Mental Hygiene 2004 38858 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov. 19, 2004 Physician Berte Helen Matheou 6:15a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Alfred House III Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days Hours 64 Yrs. 556-90-1817 4/10/1940 **Director** Greece Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23s or 28s-t show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Rockville MD Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5313 Norbeck Road 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Waitress and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Georgia Mouzala Christos Matheou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: It item 27 is any injury or other tree 14620 Bauer Dr. #4 Rockville, Md 20853 Eleanor C.Inniss/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/22/04 Wash., D.C. Glenwood Cem. \* 4 ☐ Donation 5 ☐ Other (\$ pecify) 21. Signature of Funeral Service Licerisas PHILIP D. RINALDI FUNERAL SERVICE, P. A Miles DI 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medicai as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ō in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. detached the 9☐ Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ be 1 Yes 2 1 No 3 Probably 4 Unknown been si should l Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tes 2 No of Vital ospital or Attending Physician: hours after death.
unarat Director: After this certifically filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one| Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Ving Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA ٩ 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0055694 Nov.21,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alok Mathur 4000 Olney-Laytonsville Rd Olney, Md 20832 31. Date filed (Month 32. Registrar's Signature State 2004 Registrar

		,	Registrar	State of Maryland	d / Depa		ealth a	ind Mental	Hygiene Reg. No	- ,	38859
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date Monti	n Da		3. Time of Death 430 PM
	/Medic Examin		4a. Facility Name (If not institution, give sind 623 Ponds Road	tow BARTRA treet and number)	M	4b. City, Town, or McHenry		f Death	40.	County of Death Garr	,
	Funeral Director		5. Social Security Number 6. Sex 232–52–7457	7. Age (In yrs. I. 1M 2□ F 70	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mont	of Birth h, Day, Year) - 12-15	Ta7504	placa (State or Foreign (Gry) Virginia
	nyland how		10a. State 10b. County		, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	ecto	MD Garrett	Mo	Henry						1 ☐ Yes 2XXNo
	with the	F	10e. Street and Number 623 Ponds Road			10f. Zip Code	541	`	10g. Cit	tizen of What Cou USA	intry?
336	filed within 72 hours after death with the Maryland Hygiene ther than "naturel", or Hems 23a or 28a-f show ant, the Medical Exacting Frust by notified at	by Funeral Director		2. Was Decedent Ever in U. Armed Forces? 1 ZYes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cubar □ Yes 2½ No	spanic Orig n, Mexican Specify:	gin? (Specify Yes , Puerto Rican, etc	or No-	14. Race - Amer Black, White Specify:	
21215-0036	d within 72 hor giene. ir than "nature it is Medicul E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			lent's Usual Occupa kind of work done of DO NOT use retired, Technici		of working		ind of Business/l	ndustry
d 2	be filed within ntal Hygiene. ed other than ' event, the Me	0	17. Father's Name (First, Middle, Last)		Itaaro	Icomitox	18. Mothe	r's Name (First, M	iddle, Maider		
ylan	D ≒ D ●	To B	Fred Bartram				Jos	ephine H	atton		
Maryland	O1 (0 (D)	0	19a. Informant's Name/Relationship (Type Carol B. Lorson/da	•		g Address (Street a					
d)	s 1 and 2 f Health item 27 other tre		20a. Method of Disposition	20b. P		sition (Name of natory or other place		Date		ocation - City or T	
imo	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	SINOVAL HOILI STATE		Bide Crem		26, 200	4 Dav	idsville	PA
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot <u>2005e</u> .		21. Signature of Funeral Service License	Jeurnau	/	ewmandfun 79 Miller					
J.			23a. Part1. Enter the disease, or complice shock, or Heart failure. List only on	ations that caused the death e cause on each line.	n. Do not ente	er the mode of dying	g, such as	cardiac or respira	ory arrest,		Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner (the prinal-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	uence of):	*					2 years
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Vita	Physician: The this certificateral director, page	Be	25. Was case referred to medical examiner?	ospital:		Othe	or.	of Death (Check	1		
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Division	itel or Attencrs after death al Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office			tion (Street a or Town, Stat		ral Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only 2 ☐ Medicel Exemin	icien: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	vestigation, in my or	oinion, dea	d place, and due to th occurred at the	time, date an	d place, and due	to the cause(s)
	To To	2	29b. Signature and title of certifier	whele	100	29c. License		54	29d. Da	ate signed (Mont)	OY
0+	VA		30. Name and address of person who con	infer Do	(a	Wolf /	Acres	Dr. G	alla	m, la	1) 21550
	Sta Registr			32. Registrar's Signa	lure	facely.					

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			Decedent's Name (Fig. 1)	rst, Middle, Las	sit)	-				2. D	ate of Death		3. Time of Death
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}	Examir	ner	4a. Facility Name (If not	_	street and nu	mber)		4b. City, Town, o		of Death		4c. County of Dea	th
	Funeval		27815 Rids 5. Social Security Numb		ex	7. Age (In vrs	. last birthday)	Damascu If Under 1 Year		or 24 Hrs.   8. D	ate of Birth	Montgome	
	Funeral Director		220-46-2913	1	□M 2∏ F	58	Yrs.	Months Days	Hours	Min. (A	Month, Day, Ye		thplace (State or Foreign ountry) Cyland
	pug 🔉		Usual Residence of Dec	edent c. County			ity, Town or Lo	antion				17-10   1101	
	Maryla f sho	ō		ontgom	erv	1 _	Damascu						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	Director	10e. Street and Number					10f. Zip Code			10g.	Citizen of What C	ountry?
	23a o	ai D	27815 Ridg	ge Road				20872				U.S.A.	
	er dez items	Funeral	11. Marital Status		Armed Fe	edent Ever in U proes?	J.S. 13.	Vas Decedent of I f Yes, specify Cub	Hispanic O an, Mexica	rigin? (Specify `an, Puerto Ricar	res or No- i, etc.)	14. Race - Ame Black, Whi	
36	urs aft	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ∐Yes If Yes, Gi Year or [	VB		I□Yes 2√∏No	Specify	y:		Specify:	-4+-
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene sd other then "naturel", or items 23a or 28a-f show event, the Madical Examiner must be multilled at	sted	15.	Decedent's Ed	lucation		16a. Deced	lent's Usual Occup	pation	est of warking	168	o. Kind of Business	nite VIndustry
21	within ne.	Completed	Elementary/Secondar		College (	1-4or 5+)	life. I	DO NOT use retire	d)	· ·			
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Maryland	12 should be and Mental is marked creametic ev	-	19a. Informant's Name/				19b. Mailin	g Address (Street				ity or Town, State,	Zip Code)
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altimore,	S to the		20a. Method of Dispositi 1 ☐ Burial 2 ☐ Cr.		Removal from	State		sition (Name of natory or other pla	1	Date		c. Location - City or	
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	(T)		23a. Part1. Enter the di- shock, or heart fail	sease, or comp	plications that	caused the dea	th. Do not ente	er the mode of dyi	ng, such a	s cardiac or resp	piratory arrest	Maryranc	Approximate Interval Between
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	/Medical Examiner		resulting in death)		u	(or as a consec							
	DES.	ē	Sequentially list condition if any, leading to immed	ns, iate	b. Due to	(or as a consec	quence of):	-					
	cuted od ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C								
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last		Due to	(or as a consec	quence of):						
98760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical			d								
Box 6	eath certific attending p	√/Me	IF FEMALE; 23b. Was decedent pred	anant .	23c. If yes, ou	come of pregn	ancy					23d. Date of de	livery
	death e atte	hysician/Me	in the past 12 mont 1 ☐ Yes 2 🗷 No		4□Pregr	ointh 2 ☐ Feta nant at time of o		Ectopic pregnanc Other (specify) _	У			Month	Day Year
0.	at the 1 by th etache	Phys	9 Unknown		9□ Unkn								
	w requires that the d been signed by the should be detached	by	Part II, Other significant	conditions co	ontributing to d	eath but not res	sulting in the ur	iderlying cause giv	en in Part	1. 2			o the cause of death?
Ö	w requ	letec				-							
Vital Hecords,	icien: The lav certificate has rector, page 2	ompieted							_		4a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
IIa	ien: 1 rtifical	e C	25. Was case referred to	medical					26. Plac	e of Death (Che	☐ Yes 2X ack only one)	No 1 Yes	s 2 No
_	hys his I diii	ToB	examiner? 1 ☐ Yes 2X No				] ER/Outpatien	3 DOA Ott				e 6 □Other (Spe	ecify)
Ĕ	ding P th. After t funera	ion:	27. Manner of Death 1 ANatural 5 [	Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. [		njury occurred	
UIVISION	death death ctor: y the	ficat		investigation Could not be	28e. Place	of Injury - At h	ome farm stre	M 1   eet, factory, office	Yes 2		ocation (Stree	t and Number or R	ural Route Number.
2	efor A safter i Dire od in b	Certification;	4 Homicide	determined	buildi	ng, etc. (Speci	fy)	set, factory, office			city or Town, S		orar rivota riambar,
	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	edical (	29a. Certifier 1 1 1 1 1	Certifying Phy	sicien: To the	best of my kno	owledge, death	occurred at the time	ne, date a	nd place, and d	ue to the caus	e(s) and manner as and place, and due	s stated.
	thin 24 the F the F mplete	Medi	one) 29b. Signature and title of		and man	ner stated.		29c. Licens		attroccorred at			
	F.≱ ₹ 8		· Chil	- Ly	me.	2		D424				Date signed (Mont	
	, ,	-	30. Name and address o	f person who c	ompleted caus	e of death (Iter	m 23a) (Type, i	Print)	-		NC	ovember 2	<b>4</b> , <b>4</b> 004
	10		Chitra Raja	agopal,	M.D.	18111	Prince	Philip D	rive	, 01ney	, Mary	land 20	832
	Stat		31. Date filed (Month, Da		32. R	egistrar's Signa	ature						
	Registra	AI .		VOV 2 8	2004	Sene	/	O SI	orto	1			

			1 For State	State of Maryl		irtment of F			L. O O "	38861
			Registrar  1. Decedent's Name (First, Middle, L	ast)	061	uncate or i	Dealli	Reg	J. No.	3. Time of Death
	Physici	an	-		~			Month		ear
	/Medi		Lewis A.  4a. Facility Name (If not institution, gi	G. Buck	, Sr.	4h City Tourn o	r Location of Death	Novembe	r 18 20 4c. County of I	
	Examir	ıer		_				'		
	Francis		Southern Marylan  5. Social Security Number 6.		enter yrs. last birthday)	If Under 1 Year	nton   If Under 24 Hrs.	8. Date of Birth		George's  Birthplace (State or Foreign
	Funeral Director		217-03-5315	1XM 2□F 87	Yrs.	Months Days	Hours Min.	Mar 10,	rear)	arvland
			Usual Residence of Decedent					Mar 10,	1917 19	arytanu
	yland		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Mar me-f	ţċ	MD Prince	George's	Uppe	r Marlbo	ro			1 X Yes 2 □ No
	h the	re	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wha	at Country?
	th wit	a D	14927 Main Stre	et.			20772		USA	1
	dead	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race -	American Indian,
9	after or It	E.	1 ☐ Never Married 2 ☐ Married	1 GYes 2 □ No		☐ Yes 21 No	Specify:	o rican, etc.)		White, etc.
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. sd other than "netural", or Items 23e or 28e-f show event, the Medical Exart are number or cutified at	d by	3 ₩ Widowed 4 Divorced	Year or Dates: 194	3-45		Specify.	<del></del>	Specify:	white
<u>~</u>	"net	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	(Give	ent's Usual Occup kind of work done	during most of wor	king 16	6b. Kind of Busin	ess/Industry
2	withir ene, than	m	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	,			
	filled v Hygie othar t		12 17. Father's Name (First, Middle, Las	¢1	brobr	ietor, g	eneral s		retail	store
and	I be f ntal h ed of	Be						ne (First, Middle, Ma		
Ž	should be ind Menta s marked umetic ev	70	Harry B 19a. Informant's Name/Relationship	uck, Sr.	405 14-115	- 14 (644	Sarah	Amelia		ill
Maryland	is a		Lewis A.G. Buck,			-		ral Route Number, (		00770
	is 1 and of Health itam 27 other tr		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	b. Place of Dispos		reet, op	per Marlbo		20772 y or Town, State
Baltimore,	Pages nent of I int: if its iry or o		1 ☑ Burial 2 ☐ Cremation 3 [	Domoval from State	cemetery, crem	natory or other place				
턡	it. Printmer intant injury		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>					1-23-04 U	oper mar	lboro, MD
Ba	permit. Pag Department Important: t any injury o		21. Signature di Funeral Servica Lice	NS GO		Name and Addres				
			23a. Part1. Enter the disease, or con	polications that caused the				ne, P.A.,		, MD 20736 Approximate
П			shock, or heart failure. List only	one cause on each line.		2	-		ι,	Interval Between Onset and Death
Н	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Heute / Sul	otwell	Respival	out ta	iluve		2 weeks
П	Examiner	ļ	1	Due to (or as a con	I a 3			11:00 0	60	200
Ė.		er	Sequentially list conditions, if any, leading to immediate	b. Chuoma of	os Pruce Vi	06 11011	uomav	y disea	. H	7 2 400 3
	ted nsit	nin i	cause. Enter Underlying Cause (Disease or injury	Courselie	1000	- Louil	. 1 /0			56.30000
_^	al-tra	Examin	that initiated events resulting in death) Last	Due to (or as a con		latie	VE			1 5 years
58760	icate be executed physician and s the burial-transit	a		a chronic	Lymn	hocytic	Lev	Kemier		> 10 years
687		edical		a. <u></u>	- 1 304/	(				7 10 (50.5)
ŏ	death certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date o	f delivery
ň	death s atte	cia	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2□F 4□Pregnant at time		Ectopic pregnancy Other (specify)	,		Month	Day Year
o.	the o	ysi	9 Unknown	9□ Unknown						
J.	res that the de signed by the a be detached t	by PI	Part II. Other significant conditions	contributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribu	ite to the cause of death?
rds S	quire;		chienia ama	l tibulla	Vion			1 ☐ Yes	2 210 3	Probably 4 Unknown
Records,	law requires that the death certif as been signed by the attending 2 should be detached for use a	lete	Hypertension	~				24a. Was an	24b. Wer	re autopsy findings available
Ž K	e 4 e	Completed	1191001011					autopsy performe	prio dea	r to completion of cause of th?
VItal	iclan: Th	ပိ	25. Was case referred to medical				02 Bloom of Door	th Check onlone		Yes 2□No
5		O B	examiner?	Hospital:	2 ☐ ER/Outpatient	3□ DOA Oth	0.00	ome 5 Residence		Sporifiche
ō	a Physical of the seral of the	틺	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun	y at	28d. Describe how		specily/ Nospital.
0	tth. :: Afte	ig	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year	r) Injury	M 1 🗆	k? Yes 2 ☐ No			
DIVISION	Attair dea actor by the	ifica	3 Suicide 6 Could not b	286. Place of Injury - A	At home, farm, stre	et, factory, office		28f. Location (Stre	et and Number o	or Rural Route Number,
5	al or s afte t Dir	Certification:	4  Homicide	building, etc. (Sp	ecify)			City or Town,	State)	
	hours hours inara y fille		29a. Certifier Certifying Pl	nysicien: To the best of my	knowledge, death	occurred at the tin	ne, date and place	, and due to the cau	se(s) and manne	er as stated.
	To the Hospital or Attending Phys within 24 hours after death. To the Funerat Director: After this completely filled in by the funeral di	edical	(Check only 2 Medical Example)	miner: On the basis of exam and manner stated.	nination and/or inv	estigation, in my o	pinion, death occu	rred at the time, date	e and place, and	due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	. 0		29c. License		290	. Date signed (A	fonth, Day, Year)
			Main 6. Cle	supall	me	D-77	_		11-19-0	
			30. Name and address of person who	completed cause of death (	Item 23a) (Type, F	Print)	4 11			777
	15H		Alain 6. Char	upaloup v	40 (	Jpper M	land bo	10 MI	20	) ( ( 2
	Stat		31. Date filed (Month, Day, Year)	completed cause of death (  CONTROL OF N  32. Registrates Si  2 2004	gnature	1				
	Registra	ar	NUV 2	2 ZUU4 Den	va St.	Goods				

			State of Maryland / De State of Maryland / De State 11-30-04 Registrar Amond #100 & 100 Por Fam PCC cr	epartment of H		ntal Hygier		38862
	1 4m		Registrar Amend #10e. & 19b. Per Fam PCC cr.  1. Decedent's Name (First, Middle, Last)			Date of Death	Day Year	3. Time of Death
	Physicia /Medic	_	Millie Hampton Canty		No	vember 2	22 2004	1:24a M
	Examin		4a. Facility Name (If not institution, give street and number)	-	Location of Death		4c. County of Death	
			Southern Maryland Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Clinton  If Under 1 Year	If Under 24 Hrs. 8,	Date of Birth (Month, Day, Yea	Prince Geo	orge place (State or Foreign ntry)
	Funeral Director		104 255	rs. Months Days		(Month, Day, Yea		n Carolina
	pu ,		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location				10d. Inside City Limits
	Aaryla f show	ō						1 🛣 Yes 2 🗆 No
	r 28a-	Director	Maryland   Prince George   Temple   10e. Street and Number	10f. Zip Code		10g. (	Citizen of What Cou	ntry?
	th with	aiD	Street 2601 Keating Avenue	20748			ited State	es
	r dea	uner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specif In, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Americ Black, White,	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give 3 🛣 Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 21☑ No	Specify:		Specify: B]	Lack
9	filed within 72 hours after death with the Maryland Hygiene. Other than "natural", or items 23s or 28s-f show ont, the Medical Everyland out the mullified at	Completed by Funeral	15. Decedent's Education 16a. I	Decedent's Usual Occupa (Give kind of work done of	ation	16b	. Kind of Business/In	ndustry
218	ithin 7 ne. nan "n	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired	d)	_		
121	iled w Hygier Ther th		17. Father's Name (First, Middle, Last)	eat Packer	18. Mother's Name (F		rivate Men Sumame)	
Maryland 21215-0036	d be f ental h ked of	To Be	Adam Hampton		Millie Nel	son		
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street a	and Number or Rural R	Route Number, Cit	y or Town, State, Zij	p Code)
Σ,	and 2 ealth a n 27 I		DOLOCHY DIOGHE, DUGLIECT	1 Keating	treet Temp1	e Hills,	MD 2074  Location - City or T	
ore	ges 1 if of H if iter or oth		1 KN Rurial 2 Li Cremation 3 Li Hemoval from State 1	Disposition (Name of y, crematory or other place	1	1	,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exactination and be nutified at Once.		*4 □ Donation 5 □ Other (Specify) Harmony  21. Signature of Funeral Service Licensee	y Memorial I			ndover, M	J
Ba	perm Depa Impo any i		Cleby Phills	22. Name and Addres Alexander 5538 Marlbo	S. Pope Fur oro Pike/Fo	neral Hor prestvil	nes le, MD 20	0747
r			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition ACUTE MYOCA	HEDIAL INF	AKCTION			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	of):				
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the Control of the Co	of):				
	uted d ansit	Examiner	Cause (Disease or injury that initiated events c.					
o'	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of	if):				
8760,		dicai	d					
9 xc	eath certifi attending f for use as	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of deliv	very
. Box	ne death the atter	icia	in the past 12 months?  1 Ves 2 No  9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
P.0	ac ac	Phys	9 Unknown	the underlying source of	una in Part I	23e Did tobace	co use contribute to	the cause of death?
Ś	w requires that been signed to should be det	t by	Part II. Other significant conditions contributing to death but not resulting in EWD STASE REVAL DISEASE		en in raici.			obably 4 Dunknown
COL	> 4 0	Completed	HYPERTENSION			24a. Was an	24b. Were au	topsy findings available
Re	e la has je 2	omp	The files in the second			autopsy performed 1 ☐ Yes 2 🛣	i? death?	completion of cause of 2 No
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?		26. Place of Death			
of Vital Record	Physician: this certific	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 XER/Out		4   Nursing Home	5 ☐ Residence	e 6 Other (Specialistics)	cify)
ou c	ling After fune	tlon:	1 ☑Natural 5 ☐ Pending (Month, Day Year) In	Time of 28c. Injur njury Wor M 1 □		d. Describe now i	rijury occurred	
Division	l or Attanding after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, far			f. Location (Stree City or Town, S	t and Number or Ru	ral Route Number,
á	s after al Dire	Cert	4 Homicide building, etc. (Specify)					
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	edicai	29a. Certifier (Check only (Ch	, death occurred at the tild d/or investigation, in my o	me, date and place, an opinion, death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To tha Complet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. Licens	se number	29d.	Date signed (Month	n, Day, Year)
	0		10000	D40	324	No	WEMBER 2	12,2004
			30. Name and address of person who completed cause of death (Item 23a) (					2472
L	J(		TERRY JODRIE, MID. 7503 SUR  31. Date filed (Month, Day, Year)  32. Registrar's Signature	RATTS ROA	D, CLINTO	N, MHR	TLAWD -	10 +3 >
*	Sta Registr		NOV 2 4 2004					

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health a Certificate of Death	nd Mental I		iene 0	0 L	38863
			Decedent's Name (First, Middle, Last)	2. Date of		1		3. Time of Death
	Physici	an	ANN PRISCILLA CEPOLLINA	Month		Day	Year	7.25pm
4	/Medic			m, or Location of D	eath	4c. Count	-	1 1 1 1 1 1
	Examin	ier				Prin	ca Ga	orge's
			Villa Rosa Nursing Home Bowie  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	4 Hrs. 8. Date of	Birth			
	Funeral		Months Days Hours	Min. (Month	, Day,	Year)	Mary	place (State or Foreign ptry)
	Director		220-42-2515 S9 Tis.  Usual Residence of Decedent	reb_4	+ ,	1747	Hal y	Land
	and and		10a. State 10b. County 10c. City, Town or Location				1	I0d. Inside City Limits
	Many f sh	ō	Virginia Fairfax Annandale					1 ☐ Yes 2 ☑ No
	28a	Directo	Virginia Fairfax Annandale  106. Street and Number 10f. Zip Code		10	og. Citizen of	What Cou	ntry?
	Will No.	ā				USA		
	death with the Maryland ms 23a or 28a-f show ir must be notitled at	Funerai	4804 Red Fox Drive 22003  11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Orig	in? (Specify Yes o			ce - Ameri	can Indian,
	er de item	Ě	Armed Forces? If Yes, specify Cuban, Mexican,	Puerto Rican, etc.	)		ck, White,	
2	s aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Wildowed 4 ☐ Divorced Year or Dates:			Speci	y: Whi	te
0200-61212	hour Kural		15 Decedent's Education 16a Decedent's Usual Occupation			16b. Kind of E		
Ċ	n 72	Completed	(Specify only highest grede completed)  (Give kind of work done during most life. DO NOT use retired)	of working				
7	with:	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker			Own H	ome	
B	Hygid Hygid Int,	ပို	_	r's Name (First, Mic	ddle, A	Maiden Surna	me)	
/land	ntal od o	Be	A	Frances	Kni	oht		
Ξ.	d Me d Me mark mati	2	Harold Hornbeck  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number				, State, Zij	c Code)
Ma	d 2 s th an 7 Is I		1001 7 7 7					
a,	1 an Heal em 2		20a Method of Disposition 20b. Place of Disposition (Neme of	Nov 23		20c. Location		own, State
פַ	2 = 2 5		1☑ Burial 2 □ Cremation 3 ☑ Removal from State	Nov 23		T-1-6-	17.4	madedo
baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maylan Depentment of Health and Mantal Hygiens. Dependent of Health and Mantal Hygiens, important; if floor 21 is marked other than "natural", or floors 23a or 28a-f show any injury or other treumatic event, the Madical Examination relation notified at once.					rairia	.x, v	lrginia
g n	Dependent of the poor of the p		21. Signature of Funeral Service House 22. Name and Address of Facility Fairfax Memoria		1 н	lome		
	40 = # O		M00956 M00956 Palitax Memoria	load Fair	fax	, Virg	inia	
		0 0	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	cardiac or respirato	ory arm	est,	1	Approximate Interval Between Onset and Death
Ģ	Physician			10			1	Oriset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. HUNTING TOIN'S D	ISEA	SI	=		years
	LXUIIIIII	L	Due to (or as a consequence of):					years
	sit sd	Examiner	DEMENTIA					years
	and and -tran	хап	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying				1	
Š,	oe ex clan	É I	cause. Enter Underlying Cause (Disease or injury					
04/8 190	death certificate be executed e attending physician and od for use as the burial-transit	dicai	that initiated events resulting in death) Last  Due to (or as a consequence of):					
۰ ح	e as	Q						
ŏ	ath co	Physiclan/M						
	e dei the a	sic	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b.	Did to	obecco use c	ontribute	to the ceuse of death?
ŗ.	v requires that the death certifi been signed by the attending should be detached for use a	F)			1 🗆 Y	es 2 No	3 ☐ Pro	obably 4 🗆 Unknown
<u>ທ</u> ົ	requires that neen signed b hould be deta	þ					245 1	Vere autopsy findings
Cord	equir sen s sould	ted			vvas a perfor	n autopsy med?	a	vailable prior to ompletion of cause
	lawr esbe	pje					o	f death?
r	~ - ~	Completed			1□ Y	es 2 No	1	☐ Yes 2☐ No
<u>a</u>	ysicien: The is certificate director, pag	Be (	25. Was case referred to medical examiner?	of Death (Check	only or	ne)		
<u> </u>	Z 20 0	2	1 Yes 22 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	rsing Home 5 🗆	Resid	ence 6 □0	ther <i>(Sp</i> ec	ify)
			27. Manner of Death 1º Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28b. Time of Injury Work?	28d. Desc	ribe h	ow injury occ	urred	
VISION	Attending ir death. ector: After by the fune	äţi	2 Accident investigation M 1 Yes 2					
	l or Attence ter deat Director: d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Locat	ion (S or Tow	treet end Nur n, State)	nber or Ru	ral Route Number,
5	tal or	Š						
	the Hospital or Att hin 24 hours efter d the Funerel Direct mpletely filled in by	edical	29a. Certifier (Check only (Check only Medical Examiner; On the basis of examination and/or investigation, in my opinion, deal	d place, and due to th occurred at the	the c	ause(s) and i	manner as e, and due	steted. to the cause(s)
	the F the F the F		one) and manner stated.		γ			
1	<b>1</b>	Σ	29b. Signature arrobitile of certifier  29c. License number	0100	- 1	29d. Date sigi	1	1 - 1
1	95		MY KAKUSH CULON (STIND DZ)	0,00		11	117	107
	~		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RAICES H. ARORA MD 14300G ALLANT For Signature  32. Registrar's Signature  Aparts  Aparts	201 / 1/1	<del>가</del> つ	22 R	WIF	MD 207/5
			KAKESH ARORAMD 14300GHLLANT F	OX LIV,	+ 4	22 00		, , , , , ,
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registr	ar	140 A M C C C C C C C C C C C C C C C C C C					

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State of Maryland / Department of Health and Mental Hygiere 0 0 4

38864

		1	For State Registrer		Otate of W	arytari		rtifica	te of E	Death		F	leg. No.			
		-	Decedent's Name (First, Middle	e, Last)	<u> </u>							ate of Dea	ith Day	Year		3. Time of Death
	siciar edica	_	Mary		Elizabe	th	Crit	Z			N	loveni		19, 200		_1:10 p <sup>M</sup>
<b>3</b>	mine		4a. Facility Name (If not institution	n, give s	treet and number	)		4b. City	, Town, or	Location of De	eath			County of Dea		
			Casey House						ockvi		dro a s	( D : a)		Montgon		<b>y</b> ce (State or Foreign
Fune	ral	5	5. Social Security Number	6. Sex	7. A M 2⊋F		ast birthday, Yrs.	Months	r 1 Year Days	Hours N		ate of Birth Month, Day		C	ountry	1)
Direc	tor	-	463-60-9686		-X	65	113.				Se	pt.16	), I	939	<u>T</u>	exas
and *	200	-	Usual Residence of Decedent  10a. State 10b. County			10c. City	, Town or L	ocation							100	i. Inside City Limits
f eho	l		MD Montg	rome	rv	Ga	ithers	burg								1 ☐ Yes 2 🙀 No
the N	3	eci	10e. Street and Number	Onici	- 9		201021		p Code				10g. Citi	zen of What C	ountr	y?
with a	1 2	5 │		1 17.					20	878				USA		
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. tten 27 is marked other then "naturel", or items 23a or 28a-f ehow	1	Funeral Director	15009 Whitetai		12. Was Deceden	t Ever in U.	S. 13.	Was Dec		spanic Origin? n, Mexican, Pi	? (Specify	Yes or No	.	14. Race - Am		
fer d		듣	1 ☐ Never Married 2 ☐ Mar	ried	Armed Forces 1 ☐ Yes 2X						uerto Hica	n, etc.)		Black, Wh		ite
J.S. al	1	<u></u>	3 ☐ Widowed 4 ☐ Divorced		If Yes, Give Year or Dates	:		1 🗌 Yes	2L <b>16</b> 10	Specify:				Specify:	4477	Tre
D P P		Completed	15. Deceder	nt's Educ	cation		16a. Dece	edent's Us	ual Occupa	ation during most of	workina			nd of Busines		
21215-0036 3d within 72 hours aff giene. er then "naturel", or	1		(Specify only higher Elementary/Secondary (0-12)	si grade	College (1-40)	r 5+)	life.	DO NOT	use retired	)	3			tgomery blic S		
212 Illed with Hygiene. Ther ther		0	12		4			Te	acher						CHO	OTS
nd 2		Be	17. Father's Name (First, Middle,	Last)						18. Mother's						
Maryland Id 2 should be filt Ith and Mental Hy 27 Is marked oth		0	James Richard	Cri	tz					La11a					-	2-4-1
2 sho			19a. Informant's Name/Relations							and Number o						
1 and 1 Health lem 27			Elizabeth A.	John	son -Dau		_	- Service Service		il Way	Date	-		sburg, ocation - City of		
00-		1	20a. Method of Disposition 1 ★Burial 2 ☐ Cremation	3 □R	emoval from Stat	8 0	lace of Disp emetery, cre	ematory`or	other plac							
altimore, mit. Pages 1 a partment of Heg			4 ☐ Donation 5 ☐ Other (S		58.7	Ch	estnu	and the second			/24/2	-		erndon		
Baltimo	any injury poce.		21. Signature of Funeral Service	License	At.		2	2. Name	and Addres	ss of Facility				Funer		
<b>n</b> 22 E 3	ā	1	· mm/	/U	MAS	<u>-</u>	100		,			len S		Hernd	1	VA Approximate
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r compli	ications that caus ne cause on each	ed the deat line.	h. Do not e	nter the m	ode of dyin	g, such as cai	rdiac or re	spiratory a	rrest,			Interval Between Onset and Death
Physic	all V		Immediate Cause (Final disease or condition				CELL	TJING	CAN	TER						onths
/Medi	cal		resulting in death)	1	Due to (or a			DOING	OTHE	7.4.						
Examir	ner		Commentative lies conditions	ш,											_	
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to (or a	as a conseq	uence of):									
cuted	ians:	Examiner	that initiated events													
<b>O</b> , exe			resulting in death) Last		Due to (or a	as a conseq	uence of):									
68760, rifficate be executed ng physicien and		Medical			d											
og pt	S	Ved	JF FEMALE:	7						-						
	esn. I		23b. Was decedent pregnant	2	23c. If yes, outcon 1 ☐ Live birth	ne of pregna 2 🗌 Feta	I death 3		pregnancy	/				23d. Date of e Month		ry Day Year
dea de att	0 0	<u> </u>	in the past 12 months? 1 ☐ Yes 2🙀 No		4□Pregnant 9□Unknown		leath 5	Other (	specify) _				- 1			
Records, P.O. Box The law requires that the death cer ate has been signed by the attendir	iach	Physician/	9 Unknown							an in Dart I		23e Did	tohacco	use contribute	to the	e cause of death?
S, Bs the	90 0	by	Part II. Other significent condit	ions cor	ntributing to death	but not res	sulting in the	underlying	g cause giv	ren in Part I.			Yes 2			ably 4 □Unknowi
ord en si	Ding	e e						-			-					
Records, The law requires to the has been signe	S S	be										24a. Was	psy	24b. Were prior death	autor to con	osy findings availabl npletion of cause of
The Tage	gage	Completed										1 Tes	ormed? 2 <b>∡</b> N			2 🗆 No
Vital /sicien: T	ioi.	Be	25. Was case referred to medic examiner?	al						26. Place o	f Death (C	heck only	one)			
of Vita Physicien: this certific	9 9	2	1 Yes 2 No	ŀ	Hospital: 1 🔲 Inpa	atient 2	ER/Outpati	ent 3		4 L. (4u15				6 Other (S	pecify	Hospice
og Phy ter this	neral .		27. Manner of Death 1 Natural 5 Pend	lina	28a. Date of I	njury Day Year)	28b. Time Injury		28c. Injui Wo			I. Describe	how inju	ıry occurred		
Vision Attending r death.	ē :	atic	2 Accident inves	tigation				М		Yes 2 No						10-1-16-
Division I or Attending after death. Director: Afte	a a	tific	3 Suicide 6 Could 4 Homicide deter	mined	28e. Place of building,	Injury - At h	ome, farm,	street, fact	ory, office		28f	. Location City or To	(Street a wn, Sta	nd Number or te)	Hura	l Route Number,
Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has	i pe	Certification:	***													
ospi	ly th		29a. Certifier 1 Certify (Check only 2 Medice	ing Phy	sician: To the be iner: On the basis	st of my kn	owledge, de	ath occurr	ed at the ti	me, date and opinion, death	place, and occurred	due to the at the time	cause( , date ar	s) and manner nd place, and	r as st due to	ated. the cause(s)
To the Hospitel within 24 hours a To the Funerel I	plete	edical	one)		and manner	stated.						1		ate signed (M		
To t With	COM	Σ	29b. Signature and title of certif	ier				1		se number				1 /		oog, rear
r-			Chile d	you	youl			-	DYA	2452				2/03/	9	
0			30. Name and address of perso	h whole	ompleted cause of	of death (Ite	m 23a) (Typ	e, Print)							/	
			Chitra Rajago	paĺ.	MD	971	5 Med	ical	Cent	er Dr.		Rock	wil.	le, MD		
	Stat		31. Date filed (Month, Dey, Yea	ir)	32. Reg	istrar's Sign	ature	,								
D <sub>0</sub>	aietra	3 r	DEC 0 8 200%	4	100 00000	e Ale	3									

State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Item 29d per Dr., G839, Ocentificate of Death Reg. No. 38865 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 04 16:33 Joseph Charles Di Giustino /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGAN SACRED HEAR CUMBERLAND HOSPITAL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, July 10, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 1926 Maryland **Funeral** Months 220-16-6979 1[XM 2□ F 78 Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-1 show 1ry or other traumatic event, Ite Medical Examiner must be routlined at 1 Yes 2 No WV Director Grant Mount Storm 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 26739 USA P.O. Box 160 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian. 11. Marital Status 8lack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Torelli Di Giustino Rosario Cesidio 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 160, Mount Storm, WV 26739 permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other traconce. Jean Di Giustino / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland, MD Cumberland Crematory 11/26/2004 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home 710 Church Street, Kitzmiller, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cordiac arres **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): organ falline Examiner MU HISUSTON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): P.D. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year The law requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No 4□ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 🗹 Unknown 1 □ Yes 2 □ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No raletes 2 **5**0No Division of Vital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Sanpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 28d. Describe how injury occurred 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. 27. Manner of Death Certification: After 1 Alatural Injury 5 Pending 2 🗌 No s after death. 1 🗀 Yes investigation within 24 hours after death.

To the Funeral Director: /
completely filled in by the f Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/24/04 O 00054355 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 900 Seton Drive, Cumberland, MD Mark G. Nelson, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

Ame	nde	d,5, F	.Н.	1 - For TCHD,	l1-23	State of	Marylan	d / Depa	artment <i>tificate</i>	of He	ealth a Death	ınd M	lental Hy	giene Reg. No.	00	4	38866
				1. Decedent's Name (Fire	st, Middle,	Last)							2. Date of De. Month			Year	3. Time of Death
	N.	Physici /Medi		CHARLES D	. DA	VIS							NOVEMBI			2004	1:40AM M
U	7	Examir	ner	4a. Facility Name (If not i		•	oer)		4b. City, To							of Death	
				204 SHIPP			Age (In yrs.	last hirthday)	If Under 1		If Under 2		8. Date of Birt		(UEE	N AN	
		Funeral Director		5. Posist Septity 34726	,	1. XM 2□F	53	Yrs.		Days	Hours	Min.	(Month, Da	y, Year)	1		lace (State or Foreigr itry) JERSEY
		p .		Usual Residence of Dece	dent		,						00113 20				
		laryla shov	5	10a. State 10b	County OHEE	N ANNE'S	10c. Cit	y, Town or Lo STEVEN	CATION VSVILL	E							0d. Inside City Limits  XXYes 2 □ No
		death with the Maryland ms 23a or 28a-f show rinust be riciffed at	Director	10e. Street and Number	70111				10f. Zip C					10a. Citi	zen of V	What Coun	
		23a or	ā	204 SHIPP	ING C	REEK DRIVE	₹.			2166	66					USA	,
			Funerai	11. Marital Status	-110 0	12. Was Decede	ent Ever in U.	.S. 13. \				gin? (Spe	ecify Yes or No Rican, etc.)	-			an Indian,
	98	hours after d tural', or Item al Examiner	y Fu	1 Never Married					i res, specii i □ Yes 🟋		Specify:	, Fuerto	nicari, etc.)		Specify		etc. HITE
	Ö	요 호 등	ed by	3 ☐ Widowed 4 🔯 [		Year or Date s Education	95:		dent's Usual					16h K		usiness/inc	
	15		Completed		ly highest	grade completed)	F.\\	(Give	kind of work DO NOT use	done du	iring most	of work	ing	IOD. NI	10 01 61	usiness/inc	dustry
	212	giene. er than	Com	12	(0-12)	College (1-4	or 5+)	INSURA	NCE O	PERA	TION	S MA	NAGER	AC	RIC	ULTUI	RAL
	Maryland 21215-0036	be filed withir tal Hygiene. Id other than event, the M	Be	17. Father's Name (First,		ast)							(First, Middle,	Maiden	Sumam	10)	
	yla	should ind Men imarke umaric	2	J.N. DAY		- (T Dist)							FINE			04-1- 71-	0.41
	Ma	CA 10 70 00		19a. Informant's Name/F									I Route Number				
	ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	n		20b. P	lace of Dispo	sition (Name	of			Date			City or To	
3	Ë	Pages nent of int: If it		1 ☐ Burial 2 📉 Cre  1 ☐ Donation 5 ☐		3 □Removal from Sta ecify)	ate	emetery, cren ESAPEAI				TR 1	1/20/0	S	EVE	NSVII	LLE, MD
568	Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral	Service Li	icensee		22	Name and	Address	of Facility	v					HOME PA
D		#0 = # g		JOH	2	Z MER		2(	00 S.	HARR	RISON	ST	EASTON,	MD			
					ease, or c ire. List o	omplications that cau nly one cause on eac	sed the deat h line.	h. Do not ent	er the mode	of dying,	, such as	cardiac o	or respirat <i>or</i> y a	rrest,			Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a. me	Tas	GI	C	una	1	ar	cinon	na			9 mo
	П	Examiner			- 1	Due to (or	as a conseq	uence ot):			,						
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		cate be executed ohysician and the burial-transit	Examiner	that initiated events	1	с											
	60,	oe execian a	i Ex	resulting in death) Last		Due to (or	as a conseq	uence of):									
	98760	icate l physi s the b	dicai			d											
	Вох 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent preg	nant	23c. If yes, outco							·		3d. Dai	te of delive	erv
	ă	death e atter	iciar	in the past 12 month		4□Pregnan	n 2∏Feta it at time of d		Ect <i>o</i> pic preg Other <i>(spec</i>					-		onth	Day Year
	P.O.	at the by the tache	hys	9 Unknown		9□ Unknow											
	'n	es be		Part II. Other significent	condition	s contributing to deal	h but not res	"		se giver	n in Part I.			,			ne cause of death?
	ord	w requir been si should	eted	me	1119	nan		-US 10	21				19		□ No	3 Prob	
	3ec	hast pe2s	Completed by										24a. Was autop	osv	24b.	Were auto prior to co death?	psy findings available mpletion of cause of
	<u>e</u>	n: Th ificate or, pag		25. Was case referred to	madiaal									2 No		1 🗆 Yes	2□ No
	i i	Physician: this certific ral director,	To Be	examiner?	medical	Hospital: 1 □ Inp	atient 2 🗆	ER/Outpatien	t 3 DOA		26. Place 4 □ Nui		me 5 Resi		—— S □Oth	er (Specif	iv)
	0	ter thi		27. Manner of Death		28a. Date of		28b. Time of Injury		c. Injury a Work?			28d. Describe				,,
	000	endir sath. or: Af	atic	2 Accident	Pending investiga	ition		,uty	М		es 2 🗆 N	No					
	Division of Vital Records,	or Attending ifter death. Director: After in by the fune	Certification;	3 Suicide 6 4 Homicide	Could no determin	28e. Place of building	Injury - At ho , etc. (Specify	ome, farm, stro V)	eet, factory,	office			28f. Location ( City or To	Street an vn. State	d Numb	er or Rura	al Route Number,
	ш	spital ours a ours a neral I		29a. Certifier	Sertifying	Physician: To the be	est of my kna	wiedne death	occurred at	the time	date and	d place	and due to the	cause(s)	and ma	anner as s	tated.
		To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical		ledical E	kaminer: On the basi and manner	s of examina	tion and/or inv	estigation, in	n my opi	nion, deat	th occurr	ed at the time,	date and	place,	and due to	the cause(s)
		Vithir To the	ž	29b. Signature and title o	f certifier	//	2-3	DI	29c. I	License	number		200	29d. Dat	e signe	d (Month,	Pay, Year)
	ŀ			Mal	low	MI	1/K	NC	1	HO	00	60	185		1	19/	04
				30. Name and address of	person w	ho completed cause	of death (Item	1 23a) (Type,	Print)	as	tor	1	MD		2/	60	
		Sta		31. Date filed (Month, Da		32 Reg	istrar's Signa			- /	-		/				_
		Registr	ar	1104	23	2004	me B	. Also	Med								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene | | | 38867 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Cikeithia 10:25 P<sup>M</sup> Dubard 16, 2004 4c. County of Death November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner University Hospital Baltimore 8. Date of Birth (Month, Day, Year)
Dec. 22, 1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖵 F 21 Yrs 579-06-7298 ~1982 Director Wash., Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 □ No Director Maryland Prince George's Suitland 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 5 2506 Darel Dr., #T1 20746 or Items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) illed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced 'netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Bank Teller Self-Employed s 1 and 2 should be filed voil Health and Mental Hygie Item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles S. Trezvant Annette A. Dubard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m any injury or other treum once. 2506 Darel Dr., #T1; Suitland, MD 20746 Disposition (Name of Date 20c. Location - City or Town, State Annette A. Dubard - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Lee's Crematory Clinton, MD 4 □ Donation 5 □ Other (Specify) 11/24/2004 Stewart Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 orm 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or Indition resulting in death) Gastrointestence Henowhage Physician Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. ter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 9 Reval transplant for Polycystic Kidney 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 □ No 1√2 Yes 2 □ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1xx es 2 □ No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 15 Natural 5 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carol H. Allan MD 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

Registra

State of Maryland / Department of Health and Mental Hygien 38868 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 16, 2004 **Physician** Angelo C. Diamantides 6:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery General Hospital 01ney Hours Min. 8. Date of Birth (Month Pay, Year) 19 If Under 1 Year Months Days 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1**∑**M 2□ F Greece 579-50-2707 85 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any jury or other traumatic event, the Medical Examinat has notified at once. 1 √ Yes 2 □ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20905 14416 Tarpon Terrace Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: If Yes, Gree Year or Dates: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Businessman Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Cois Christos Diamantides 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4601 North Park Ave. #716 Chevy Chase, MD 20815 Dina Diamantides-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1X Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. 11/19/2004 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signatyre of Funeral Service License 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Duoden Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner w Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (br as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ page 2 should be 3 ☐ Probably 4 Nhknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 2 ER/Outpatient Certification: To 3 DOA 6 ☐ Other (Specify) 1 Tyes Inpatient this Date of Injury (Month, Day 28d. Describe how injury occurred 27 Mannes of Death 28b. Time of 28c. Injury at Work? 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: A 2 Accident 3 🖺 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide filled in 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai To the within 2. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Universita Ninala 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 22 Registrar

,	•	State of Maryland / Department of Health and Me Amend Item 18 per th G838 12-16-04 tas Certificate of Death	ental Hygiene Reg. No 2004 38869
			2. Date of Deeth 3. Time of Death
	Physician /Medical	Mabel Elizabeth Divelbliss	November 26,2004 8:30 P.M.
	Examiner	4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Local	,
		Williamsport Nursing Home Williamspor	
	Funeral	5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 18 Months Deys Hours Min. 2XF 82Yrs.	B. Date of Birth (Month, Dey, Yeer) (State or Foreign Country)
	Director	235-28-3670 1UM 2MF 82Yrs. A	pril 20,1922 PA
	wor.	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Man	MD Washington Hancock	1√2 Yes 2□ No
	vith the Mar or 286-1 s be not the Director	10e. Street end Number 10f. Zip Code	10g. Citizen of Whet Country?
S	23e ust b	6 West Main Street Apt. 35 21750	USA
	flar death v r items 23 frer must Funeral	11. Marital Status  12. Wes Decadent Ever in U,S. Armed Forces?  13. Wes Decedent of Hispanic Origin? (Specific Forces) If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc.
20	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Medical Examiner must be notified at empleted by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify: Year or Dates:	Specify: White
Ş	thurst ed t	11	
215	ed within 72 ho ygiene. ser than "naturi nt, the Medical I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	1
21	giene grant pr The	8 Homemaker	Own Home
P	be file tal Hy d othe event	17. Fether's Name (First, Middle, Last)  18. Mother's Name (  Ida Skint	First, Middle, Maiden Sumame) ner Richards <del>ner</del>
<u>Va</u>	Ment Ment Ment arked		
Maryland 21215-0020	2 sh and is m raum	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rurel)	
_ 	1 and Health	Marcella L. Willoughby/daughter 240 North PA. Ave. Hancocl 20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Saltimore,	permit. Peges 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.  To Be Comp	1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State	
ᇩ	it. Portma	4 Donation 5 Other (Specify) Cedar Grove Cemetery 11/ 21. Standard Of Funeral Service Licansee 1/22. Name and Address of Facility	30/04 Warfordsbur, PA
Ba	Depe July Suny		141 West Main Street
5		23a Part Forer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or	.A. Hancock, MD 21750-0368 respiratory arrest, Approximate Interval Between
7	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	Interval Between Onset and Death
	/Medical	Immediate Cause (Final disease or condition a. Recal Failure	months
2.	Examiner	resulting in death)  a. /e//a///// Due to (or as a consequence of):	111111111111111111111111111111111111111
/ · · t	12 = 5	Insulin Dependent Diabetes	years.
Ĕ. W	icate be executed physician and standard transit		
5 00 c 68760,	be ey ician bunia bunia	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	
. a.b.		that initiated events  Due to (or as a consequence of): resulting in death) Last	
2 //	leath certific attending plater use es i	d	
υ <b>ຫ</b>	death e atte d for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobecco use contribute to the cause of death?
P.O.	t the by the teacher		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
-	as the general period of the de de de de de de de de de de de de de	Chronic Lymphocytic Leukemia	
ળ હો ords,	The law requiras that the death certificate has been signed by the attending page 2 should be dateched for use e.	Congestive Heart Failure	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause
) je	law ras bo	Jest to free free free free free free free fre	of death?
E	cate to page : page :		1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
Vit.	ician: ector	25. Wes case referred to medical 26. Place of Death (examiner?	
⁄ଏ∆b Division of Vital Records,	Physic this or ral dire	1 Inpatient 2 EH/Outpatient 3 DOA 4 UPNursing Home	e 5 ☐ Residenca 6 ☐ Other (Specify)  dd. Describe how injury occurred
on	ding th. After fune	1 □Natural 5 □ Pending (Month, Ďaý Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
S	Atten r dea octor by the	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28	of Location (Street and Number or Rural Route Number, City or Town, State)
Ö	tai or Attending P rs after death. ai Director: After t led in by the funers Certification:	4 ☐ Homicide building, etc. (Specify)	only of Fown, store)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completally filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only   Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred	
	the H hin 24 the F nplets	one) and manner stated.	
	To tro tro tro	255. Olgitalis and the transfer	29d. Date signed (Month, Day, Yeer)
		Cynthe Kuther-Sands, no D47451	November a 1, 2004
	H	30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)  CYPTH & Kuttner-Sands MD Williamsport Nursing Home	November 27, 2004 154 North Artizan Street Williamsport, Maryland 21795
	State	31. Date filed (Month, Day, Year) DEC 07 2004  32. Redistrer's Signature	williamsport, may floria all'is
	Registrar	UEC 0 7 2004 Dener O Apolis	

8:30Pm

November 26,2004

Divelbliss

Mabel Elizabeth

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a, PtII, 23b, 25, 27, 28a-f per ME G841, 03/22/05 db Reg Model of Death and Mental Hygiene dhb Rog No D 1. Dacedent's Nama (First, Middla, Last) 2. Deta of Death Month Yaar **Physician** Harold Raymond Evans November 25, 2004 7:15 pm /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva straat and number) 4c. County of Deeth Examiner Garrett County Memorial Hospital 0akland Garrett If Undar 1 Yaar Months Days Under 24 Hrs. Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (În yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Funeral 1 X M 2 □ F 20, 1926 West Virginia Director 236-32-5858 78 Usual Residence of Decedent filed within 72 hours after death with the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 0akland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21550 USA 3443 Fingerboard Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Produce/Groceries 8th Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental tem 27 is marked or Pages 1 end 2 should be Wilbur Bessie Winters 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 3443 Fingerboard Road, Oakland, Md. 21550 Vendetta D. Evans/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State õ Department of Important: If It 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/29/04 Deer Park, Maryland Deer Park Cemetery 21. Signature of Funeral Service Licensaa 22. Name and Address of Facility Stewart Funeral Home 23a. Part1. Entar the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart vailure. List only one cause on each line. Approximate Interval Between Onsat and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical 24 hrs Subdural Hematoma Examiner Due to (or as a consaquance of): MAPPROVED BY MEDICAL EXAMINER Examiner -ASVD Attending Physician; The law requires that the death certificate be executed for use es the bunal-trensit Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Due to (or es a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical CERTIFIC Dua to (or as a consaguance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Hypertensive Arteriosclerotic Pt TT HBPģ Cardiovascular disease 24b. Were autopsy findings available prior to completion of cause of death? page 2 should edical Certification: To Be Completed 24a. Was an autopsy Renal failure 1 ☐ Yes 2 ☐ No 1 \_ Yas 2 No filled in by the funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA After this 27. Manner of Death 28a. Data of Injury (Month. Day Year) 28b. Time of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation 2 A Accident 1 ☐ Yas 🛣 No Probable fall death. 11/24/2004 Unknown To the Hospital or Attend within 24 hours after death To the Funerel Director: 3 Suicida 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Unknown 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicide Unknown 29a. Certifian Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, end due to the ceuse(s) and menner as steted. 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to tha causa(s) and mannar stated. completely (Check only one) 29b. Signature and titla of certifier 29c. Licensa number 29d. Data signad (Month, Dey, Yaer) 15+VA 30. Nama and addrass of person who completed cause of death (Itam 23e) (Type, Print) 311 N. Fourth St., Oakland, Md. 21550 Thomas Johnson M.D. 31. Data filad (Month, Day, Year) 32. Registrar's Signatura Registrar DHMH 16 Rev 6/95 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygpene 🛭 🗓 38871 1 - State Registral Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** William Keith Evans November 24 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner astor HOSAIN lemorial If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. **™** M 2□F 79 218-16-8286 Yrs. Director July 1925 Usuel Residence of Decedent 72 hours after death with the Maryland 10b. County 10c, City, Town or Location 10a. State nd 2 should be filed within 72 hours after death with the Marylan filth and Mental Hygiene. 27 is marked other than "naturel", or items 23a or 28a-1 show treumatic event, the Madical Examinat must be notified at 10d. Inside City Limits 1 ☐ Yes 🌡 ☐ No Talbot McDaniel Director MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9901 Wades Point Road 21647 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder- Foundry Self Employed 11 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Louise Sullivan Lomax Harry Morrell Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 Wades Pt. Rd. McDaniel, MD, 21647 Betty Ann Morris Evans (wife) of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of P
Important: if ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Christ Church Yard 11-27-2004 St.Michaels, MD R. Carroll Hurley Funeral Home, PC 21. Signature of Funeral Service Licenses R. Candle Hull 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Box 518, St. Michaels, Md. 21663 de of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovarcular accident to days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner End slage moulles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-transit chronce atreal years Due to (or as a consequence of): Box 68760. Physician/Medical URASE IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month 4 Pregnant at time of death 5 Other (specify) P.O. the ۾ signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Chrema 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Swall cell eune cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Tyes 1 Yes 2 No the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending death. 1 Yes 2 No investigation Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide within 24 hours a To the Funeral C 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11124/04 SMX D0046020 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 506 Idlewild Ave., Easton, Md. 21601 Dr. Syed Ali 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 29 2004 > Registrar

DHMH 17 Rev 1/2001

Registrar

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	•	For State Registrar	State of M	aryland		rtment of H		d Mental Hyg	giene 001	+ 38873
		Decedent's Name (First, Middle, La	st)			- 1		2. Date of Dea Month	th	3. Time of Death
Physicia /Medic		DARLENG			EL			1)	27 0	4 2120 PM
Examin	er	4a. Facility Name (If not institution, giv	1 10	. (, 0		4b. City, Town, or	Location of De	eath	4c. County of	Death
Funeral		5. Social Security Number 6. S	V - V	lemo	ast birthday)	If Under 1 Year	If Under 24 h		9	Birthplace (State or Foreign
Funeral Director			□M 213F	58	Yrs.	Months Days	Hours N	lin. ( <i>Month. Dav</i>	9, 1946	Country) Maryland
pun		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Loc	eation				10d. Inside City Limits
ith the Maryian or 28a-f show	ō		rrett	100.0.0	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0ak1	and			1 ☐ Yes 2 ☒ No
r 28a-	Director	10e. Street and Number	LIELL	1		10f. Zip Code	anu	1	log. Citizen of Wha	at Country?
th with	aiD	18 O'Brien Road					21550		USA	A
ler death w Items 23s	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	?	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - Black, 1	American Indian, White, etc.
rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No	1	☐ Yes 2⊠ No	Specify:		Specify: \	White
Ind Z IZ IZ 12 COOO be filed within 72 hours after death with the Maryla last Hygiene than "naturel", or items 23a or 28a-f shov event, the Medical Examinatinasi be multified at		15. Decedent's E	ducation		16a. Deced	ent's Usual Occup	ation		16b. Kind of Busin	ess/Industry
thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	life. C	kind of work done of NOT use retired	during most of	working		
iled w tygier her th		11th 17. Father's Name (First, Middle, Last				Bookkee		Name (First, Middle,		urant
d be fi	) Be	Robert -		Sparro	าพ		Liliar			nompson
ore, Mary granted Z. I.Z. 10-0000 set and 2 should be filed within 72 hours after death with the Maryland of Health and Mentall Hygiene. If feem 27 is marked other than "naturel", or items 23s or 28s-f show if other treumatic event, the Medical Examinating the multibud at	ဥ	19a. Informant's Name/Relationship (		Parre		g Address (Street		Rural Route Number		
and 2 and 2 ealth a m 27 is		Kimberly Bauer/da	aughter		18 0	Brien R	load, Oa	kland, Md	. 21550	
Pages 1 and of the page of the		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐	Removal from State		lace of Dispos emetery, crem	sition (Name of natory or other place	(e)	Date	20c. Location - Cit	y or Town, State
: Pag tment tent: jury c		* 4 ☐ Donation 5 ☐ Other (Special	y)			matory	-	/1/2004	Morganto	wn, WV
permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Lice	1599		St	Name and Address	neral H	lome		
		23a. Part1. Enter the disease, or com	plications that cause	d the death				, Uakland . diac or respiratory arr		Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final	one ceuse on each I	ine.		F-1		Market	. 0.	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	uence of):	ercii	حرهاس	naryva	Javar 10010	year)
Examiner		Sequentially list conditions,	b					<u> </u>	2-12	
ed sit	iner	Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury	Doe to (or as	a consequ	auriculoth					
execut and and	Examin	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):					
cate be executed oblysician and the burial-transit			_ d							
The could us, I	Physician/Medical	IF FEMALE:								
death certifice attending ph	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pregnancy	,		23d. Date o Month	f delivery Day Year
that the de ed by the a detached f	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant a 9□Unknown	it time of de	eath 5	Other (specify)				•
i that i		Part II. Other significant conditions	ontributing to death t	but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
w requires that seem signed to should be detailed.	ed by	Type II	) rabet	es	Mel	1,745		1 🗆 Y	es 2□No 3[	Probably 4 Unknown
law reas bee	plet	Congest	ine h	la	A F	ullure	2	24a. Was a	an 24b. Wer	re autopsy findings available r to completion of cause of
vital nec	Completed							perfor 1 ☐ Yes	med? dea	th? Yes 2□ No
ricien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth		Death (Check only or		
8 E B	. To	Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatient 28b. Time of	3□ DOA 28c. Injun		g Home 5 Reside	ence 6 Other (	Specify)
rth. : Afte	ation	Natural 5 Pending 2 Accident investigatio	(Month, Da	ay Year)	Injury	Wor	k? Yes 2∐No			
Attended rector by the	Certification:	3 Suicide 6 Could not be determined	289. Flace of III	jury - At ho tc. (Specify	me, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and Number o	or Rural Route Number,
Itel or ref Diale	Cer				,					
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical			of examinat				ace, and due to the c ccurred at the time, d		
o the ithin 2	Mec	29b. Signature and title of certifier	and mainer si			29c. Licens	e number	2	9d. Date signed (A	Month, Day, Ygar)
FSFO		Paul Da	- Druce	Da.	De	HT	615	4	11/2	7/04
6		30. Name and address of person who	completed cause of	death (Item	23а) (Туре, Р	Print)	1 / 1	~	6	0 44 5
2		Kaul Danie	I Miller	- I	υ,	67Wc	1417	enes W	Car	arex VIII)
Sta Registr		31. Date filed (Month, Pay, Year)	2004	rar's Signat	N. A	230%				121510

		1 - For State of Maryland / I	Department of Health and M Certificate of Death		ene 2004 38874
1		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physi /Med		M 13 1 13	ex	Novembe:	r 19, 2004 8:43 a <sup>h</sup>
Exam			4b. City, Town, or Location of Death		4c. County of Death
		3200 Plum Point Road	Huntingtown		Calvert
Funera Directo		5. Social Security Number  557-28-0193    6. Sex   1 □ M 2 □ F   7. Age (In yrs. last bit   84	Months Days Hours Min	8. Date of Birth (Month, Day, Jan. 12,	Year) 9. Birthplace (State or Foreig Country) 1920 Pennsylvania
and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
Maryl febo	ō	MD Calvert Hur	ntingtown		1 ☐ Yes 2 🏋 No
the 1	Director	10e, Street and Number	10f. Zip Code	10	g. Citizen of What Country?
3a ol			20639		U.S.A.
deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
partilling 19, Mar y fail of Z L 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f ehow any injury or other traumatic event, the Medical Eraculture must be rediffied at	۵	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		Specify: white
72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	. Decedent's Usual Occupation (Give kind of work done during most of work	ting 1	6b. Kind of Business/Industry
dithin at h	aigu	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
led w lygier her th			secretary	e (First, Middle, M	U.S. Government
d be fill male of the control of the	Be				
hould d Mei mark matic	5		Minnie  D. Mailing Address (Street and Number or Run		
Wid sid 2 s th an th an traus		, , , ,	200 Plum Point Rd., H		
Heal tem (	1	20a Method of Disposition 20b. Place of	f Disposition (Name of		Oc. Location - City or Town, State
Pages ent of nt: If i		1 M Buriai 2   Cremation 3   Removal from State	uel UMC Cemetery 11/2	2/04 H	untingtown, MD
srmit. Pages epartment of portent: If it	e ouce	21. Signature of Funeral Service Light see	22. Name and Address of Facility		
H 902 9	OI .	Duya (Helbach	Rausch Funeral Hom		
		23a. Part1. Enter the sease, or complications that caused the death. Do shock, or healt filter. List only one cause on each line.		/	st, Approximate Interval Between Onset and Death
Physician		resulting in death)	STATUS ALTERAT	1100	DEMENTIN MONTH
/Medica Examine		Due to (or as a consequence	of):	,	
	e e	Sequentially list conditions, b. Due to (or as a consequence	of):		
uted 3 ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
J, exect in and ial-tra	Exa	resulting in death) Last  Due to (or as a consequence	of):		
icate be executed physician and the burial-transit	dicai	d			
rtifica ng ph	1 0	)			
The COLOS, T.O. BOX of The law requires that the death certificate has been signed by the attending lags 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
fhat the ed by detac			in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
uires uires sign ld be	d bv			1 🗆 Yes	2 □ No 3 □ Probably 4 ☑ Unknow
necords he law requires has been sign ge 2 should be	lete	S/P HIP FRACTURE DECUBITUS ULCE	5725	24a. Was an	24b. Were autopsy findings available
VICAL DEC Sicien: The law s certificate has b lirector, page 2 s	Completed	9000		autopsy	prior to completion of cause of death?
(0 22	a a	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 2 h (Check only one	ZNo 1 □ Yes 2 □ No
OI VITA Physicien: this certific ral director,	ToB	1 Tyes 2 No Hospital: 1 Inpatient 2 ER/O	Othor	,	ice 6 Other (Specify)
ding Phys			Time of 28c. Injury at Work?	28d. Describe how	v injury occurred
Attending at death.  Sector: After by the fune	atio	2 Accident investigation	M 1 Yes 2 No		
or Attender de lirecte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fi building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town,	eet and Number or Rural Route Number, State)
To the Hospital or Attending Physicien: To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical Ce		e, death occurred at the time, date and place,	and due to the cau	use(s) and manner as stated. e and place, and due to the cause(s)
the I thin 2 the I	Med	one) and manner stated.  29b. Signature and title of certher	29c, License number		d. Date signed (Month, Day, Year)
N V			029657		11/22/04
يو.		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		-
15		Charles A. Judge, M.D., 110 Hospi	tal Rd., Suite 310, F	Prince Fr	ederick, MD 20678
	State		K how to		
Regi	suar	SA LOUTY JUGGIES	v. Harre		

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				artment of Health and Me rtificate of Death	ntal Hygien Reg. Ņ	2001
ı	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> Allan Lyman Fletcher		Date of Death Month Divorphie	3. Time of Death 18 2004 11:52 A M
	Examir		4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital	4b. City, Town, or Location of Death Rockville		c. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216 22 0650 1₺ M 2□ F 76 Yrs.		Date of Birth (Month, Day, Year May 12 I	_
	e Maryland a-f show	ctor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Lot   Md .   Montgomery   Germant			10d. Inside City Limits 1 □ Yes 2 No
	with the	I Dire	10e. Street and Number  10 Valleyside Court	10f. Zip Code 20874	-	Citizen of What Country? United States
0036	rs after death , or Items 2:	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Nover Married 2 Married 1 Nover Married 2 Nover Married 2 Nover Married 1 Nover M	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Rin 1 ☐ Yes 2 No Specify:		14. Race - American Indian, Black, White, etc.  Specify: White
00-6121	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, I're Medical Examiner must be notified all	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation I kind of work done during most of working DO NOT use retired) Welder	16b. I	Kind of Business/Industry
and 2	- 0 -	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (/		
ıyıa	should by marked marked	Tol	George Clyde Fletcher  19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	Anna  ng Address (Street and Number or Rural F	Frances	or Town State Zin Code)
e, Ma	tealth aum 27 is im 27 is ber trau		Clara A. Fletcher / Wife 10	Valleyside Court, G	Germantown	n, Md. 20874
Baitimore	perrait. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 is marked any injury or other traumatic and one.			osition (Name of Date of Matory or other place)  Cemetery 11/23		ockville, Md.
ga	Departition Depart		21. Signature of Funeral Service Licensee  Muriel H. Beerhu  22	Murie 1 H. Barber F P. U. Box 5038, L		
	Physician /Medical Examiner	er	23a. Part 1. Enter the dise e, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on e ch line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate			Approximate Interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. The to (or as a consequence of):  c. Due to (or as a consequence of):  d.			
O. Box	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use a	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
cords, r	equires that en signed b	by	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		use contribute to the cause of death?
	The la	Completed			24a. Was an autopsy performed? 1 Yes 2 1 No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
N VICA	Physician: r this certifica ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death /C		6 □Other (Specify)
	ng (fter		27. Manner of Death  1 Autural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  1 Accident investigation	f 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No	d. Describe how inju	ry occurred
<u>~</u>	tal or Atters after de al Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office 28f	. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death one)  Certifying Physician: To the best of my knowledge, death one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and/or invariant one of the basis of examination and or invariant one of the basis of examination and or invariant one of the basis of examination and or invariant one of the basis of examination and or invariant one of the basis of examination and or invariant one of the basis of examination and or invariant one of the basis of th	occurred at the time, date and place, and vestigation, in my opinion, death occurred	due to the cause(s at the time, date and	and manner as stated. d place, and due to the cause(s)
	Within Value of the Comp	ž	29b. Signature and time of certifier	29c. License number  0 - 20178		ate signed (Month, Day, Year)
	(7)		30. Name and address of person vino completed cause of death (Item 23a) (Type	Print) NSSCU Ave 6=	ithershure	j Md.
i	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 2 2004 32. Pegistrar's Signature	Sparks		

			1 - For Stete Registrar	State of M	laryland /		artment o			and Men		00	) 4	3887	76
	Physic	an	1. Decedent's Name (First, Middle, Last	")						2. [	Date of Deat	h	Year	3. Time of De	eath
	/Medi	cal	CHARLOTTE	ELAINE		FRE					OVEMBE	R 20,		4:00A	M
	Examir	ıęr	4a. Facility Name (If not institution, give FREDERICK MEMOR	STREET AND NUMBER			4b. City, To			f Death		4c. County			
	Funeral Director		5. Social Security Number 6. Se 216-30-3443	х Дм 2 <del>Д</del> F	ge (In yrs. last I	Yrs.	If Under 1 \ Months D	Year Days	Hours 1	Min.	Date of Birth Month, Day,	Year) 1933	Cour	olace (State or F otry) Sylvani	_
	and		Usuel Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation						. 1	0d. Inside City I	Limits
	e Maryl Ba-f sho	Director	Maryland Frederic	:k	Thur									1X Yes 2	
	with th		10e. Street and Number	- 4-			10f. Zip Co				10	0g. Citizen of		ntry?	
	eath v	Funeral	614 East Main Stre	12. Was Decedent	EverinIIS	12 1	Vas Deceden	788	nanio Orio	ring /Sagaiby	Voc. or No.	U.S	.A.	an Indian	
980	hours after death with the Maryland tural', or Itams 23a or 28a-f show at Examiner must be notified at	by	1 □ Never Married 2 □ Married 3 1 ◯ Widowed 4 □ Divorced	Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	?	'	f Yes, specify	Cuban,	, Mexican,	, Puerto Rica	n, etc.)		ck, White,		
2-0	72 hours "natural",	Completed	15. Decedent's Edu (Specify only highest grad		16	a. Deced	tent's Usual C	ccupati	ion	of working		16b. Kind of B			
2	d within 72 ho piene. r than "natur ine Modical	mple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work of DO NOT use r			or working					
2		e Co	17. Father's Name (First, Middle, Last)				Seamst			r's Name (Fin	et Middle A	: Clai Maiden Suman		ock	
/lan	be d d d	To Be	Arthur Buchanan							a Zimm		iaioeri Suman	110)		
Maryland 21215-0036	A DE E		19a. Informant's Name/Relationship (T) Michelle L., Freeze									City or Town, Mary			
	s 1 and 2 of Health a item 27 lg othar trai		20a. Method of Disposition	(24481121	20b. Place	of Dispo	sition (Name	of		Date	- 1	Oc. Location			
E	Pages nent of int: If it		1 ☐ Burial 2X Cremation 3 ☐ F  3 ☐ Other (Specify)	Removal from State	1	-	natory or othe g Crema			1/23/0	4 Sr	nithsbu	irg. N	Maryland	d
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		21. Signatur Fureral Service Licen	Parle	4							RAL HOM MD 21			•
			23a. Part1. Enter the disease, or compl shock, or hear failure. List only o	ications that cause ne cause or each	d the death		er the mode of							Approximate Interval Between	en
	Physician		Immediate Cause (Figal disease or condition	Myon	ARABIAL		NEARC	_71	02					Onset and Dea	ath
	/Medical Examiner		resulting in death)		a consequence	e of):								,	
	A	er	Sequentially list conditions, if any, leading to immediate	0.	a consequence		TERM	D	パンモ	NE				)NENOW	Cic
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events												
Ö,	cate be executed obysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence	e of):					·				
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dlcal		d									-		
Вох 6	eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy				101-101			22d Day	te of delive		
o.	the y th	Physician/Me	in the past 12 months?  1 \( \text{Yes} \) 2 \( \text{No} \)  9 \( \text{Unknown} \)		2 Fetal deat		Ectopic pregn Other (specif					Mo		Day Yea	r
٣,	s that gned b	by Pt	Part II. Other significant conditions con		out not resulting	in the ur	iderlying caus	e given	in Part I.	2	23e. Did tob	acco use conti	ribute to th	e cause of deat	h?
ord	w requires that been signed should be det	ted !	KENAL TAIL	URE						_	1 🗆 Yes	s 2□No	3 Proba	ably 4 🗆 Unkr	nown
Records,	2 2 2	Completed	PREUMONIA							2	24a. Was an autopsy	' _   F	prior to con	sy findings avai	ilable e of
												No 1	death?	2□ No	
Vital	Physician: this certificant	o Be	25. Was case referred to medical examiner?	lospital:	ent 2 ER/C	Lutrations	3 DOA	Other:		of Death (Che		nce 6 Oth			
1 of	ig Phy ter this neral c	-	27. Manner of Death	28a. Date of Inju	ıry 28b.	Time of Injury	28c.	Injury at Work?		_		v injury occurr		)	
Sior	Attanding Ir death. actor: After by the funer	catlo	1 Accident 5 Pending investigation	(11011,01)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				s 2 🗆 N	0					
Division	or Attano after death Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In building, et	jury - At home, t tc. (Specify)	arm, stre	eet, factory, of	fice			ocation (Stre City or Town,		er or Rurai	Route Number,	
_	To tha Hospital or Attanding I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer		29a. Certifier 12 Certifying Physical Check only 2 Medical Exemi	sician: To the best	of my knowledg	je, death	occurred at the	ne time,	date and	place, and d	ue to the cau	use(s) and ma	nner as sta	ated.	
	To tha H within 24 To tha F complete	Medical	one)	and manner st	ated.	na/or inv				occurred at					
1	To To	~	29b. Signature and title of certifier	2 4.				cense n				d. Date signed			
			30. Name and address of person who co	empleted class of c	leath (Item 325)	(Type f	Print)	60	469			11/20	0/20	004	
	5		JEREMY YOSPI	1, 172	Thoma	مرار ه	ים השמו	2 -	witz	202	From	RYK	MO	21702	
	Sta	100	31. Date filed (Month, Day, Year)		ar's Signature	4	1	20-	1		1	1	1.00		
	Registr	ar j	NOV 2 2 2	004	-	1	juge	Carried States	1						

			For Stata Ragistrar				artment of H		nd Ment	al Hygie	611	104	3887	7
	/sicia: ledica		1. Decedent's Name (First, Middle,	suler						ate of Death Ionth	Day - 2	Year 004	3. Time of Death 5:60A	Λ
Exa	amine		4a. Facility Name (If not institution, solution)  5. Social Security Number 6		r) Nge (In yrs. last birt	thday)	4b. City, Town, or	Location of URES	4 Hrs 18 D	eate of Birth	4c. County	rol	(State of Foreign	
Fund Direct			214-10-1035 Usual Residence of Decedent	1□XM 2□F		Yrs.	Months Days	Hours	Min. (N	fonth, Day, Y	<sup>ваг)</sup> 1917	Mary	lace (State or Foreig try) Land	
e Maryland	The dat	ctor	10a. State 10b. County  Maryland Carrol	1	10c. City, Town							11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
th with th	or ag ter	al Director	10e. Street and Number 7200 3rd Avenue				10f. Zip Code 2178	4		10g	Citizen of V		try?	
ING Z1Z13-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23a or 28e-f show	Examiner in	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1	;? 7 No		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2 ☒No	ispanic Origi n, Mexican, Specify:	in? (Specify Y Puerto Rican	es or No- , etc.)		ce - Americ ck, White, o	etc.	
27275-0 1 within 72 ho jiene. rthen "natur	The Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give life. [	lent's Usual Occupa kind of work done o DO NOT use retired ch Direct	during most o	of working		b. Kind of B		lustry	_
		lo ge	17. Father's Name (First, Middle, La William Fowler					18. Mother's	s Name (First 21 Burk	t, Middle, Mai			idgel les	
and 2 shoule ealth and Merit m 27 is mari	other treumatic		19a. Informant's Name/Relationship Ardis F. Cohen	(Type, Print)	163	34 5	g Address (Street a		Street	Balti	more,	MD 2	1230	
<b>∩</b> ∘ •	_		20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3  `4 □ Donation 5 □ Other (Spe		e cemeter	y, cren sbur	sition (Name of natory or other place g Cremate	ory 11		Šmi	thsbu	rg, M	aryland	
<b>Baltim</b> permit. Pag Department Importent: I	any in		21. Signature of Juneral Service	1/11	*	112	Name and Address DBERT E. 201 NORTH	MARKE	ET ST.,	FREDE	RICK,	MES, MD 2	1701	
cate be executed Examily sician and position and positions and positions and positions are set to be set t	cal ner	Cxam	23a. Parf1. Enter the disease, or consequence, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Due to (or a b Due to (or a c	s a consequence of	of):	0		ardiac or resp				Approximate Interval Between Onset and Death	5
death certifi	or use as	nysician/medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death		Ectopic pregnancy Other (specify)				23d. Dat	te of deliver	y Day Year	
ords, F.C. requires that the decen signed by the a	and be deta	y y	Part II. Other significant condition:	contributing to death	but not resulting in	the un	iderlying cause give	en in Part I.	23	3e. Did tobac	co use cont	ribute to the	e cause of death?	
The law ate has b	N I	completed								4a. Was an autopsy performed □ Yes 2	1?	Were autoporior to comdeath?	sy findings available pletion of cause of 2 No	
o	0	2	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death		jury 28b. T	-	28c. Injury Work	at						
DIVISION pitel or Attending urs after death. prel Director: After	n ka ul beill	∟ د	3 Suicide 6 Could no determine	building, e	njury - At home, far etc. <i>(Specify)</i>		-		Ci	ty or Town, S	tate)	-	Route Number,	
o the Hosp Althin 24 ho o the Fune	ompletery t	Medical	29a. Certifier (Check only one)  2□ Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examination and	, death d/or inv	occurred at the timestigation, in my op	nion, death	place, and du occurred at th	he time, date	e(s) and ma and place, a Date signed	and due to	the cause(s)	_
			30. Name and address of person of	O completed cause of		Туре, Г	Doog	5813	7	11/1	19/0	14		
Red	State	_	31. Date filed (Month, Day, Year)		Store/ trar's Signature	A	4 1	30"	7 w	estin	rste	Mi	O Wis	>

			1 - For State Registrar	State of N	Maryland / D	epartme Certifica			nd Me		ien2e () () ()	38878
ı	Physici /Medio Examir	cal	David     Alexa     Facility Name (If not institution, gives	nder	Grier	4b. City	, Town, or	Location of	N	Date of Deat Month	Day Ye	5:05 PM <sup>M</sup>
	Funeral Director	iei	415 Rolling Road 5. Social Security Number 6. S		Age (In yrs. last birt	Sa	lisbu er 1 Year		4 Hrs. 8.	Date of Birth (Month, Day,	Wicom Yeer) 9. 3, 1930 Ma	Birthplace (State or Foreign Country)
lore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menial Hygiene. Int: If tem 27 is marked other than "neturel", or thems 23a or 28e-f show int: If tem 27 is marked other than "neturel", or thems 23a or 28e-f show int or other treumetic event, It is Marylea! Exercitied and the male is a context of the market in the mark	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Wicomi  10e. Street and Number  415 Rolling Road  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grave)  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last, Alexander The same (First, Middle, Last	12. Was Decede Armed Force Willyes 2[ If Yes, Give Year or Date: ducation Inde completed)  College (1-4c) 3  OadVine Type, Print) (wife)	s? No AIR s: FORCE  16a. Or 5+) Or  Grien 19b. 41 20b. Place of cemeter.	13. Was Decifi Yes, sp 1 Yes  Decedent's Us (Give kind of wife. Do NOT  Mailing Address  L5 Roll Disposition (Nay, crematory or	all Occupance done a cuse retired, easur	specify:  ation furing most of the results of the r	in? (Specification of working  's Name (For Rural For Salis  Date	fy Yes or No- can, etc.)  First, Middle, M.  Route Number,	Og. Citizen of What  USA  14. Race - A Black, W Specify:  16b. Kind of Busine  Industria Maiden Sumame)  M City or Town, State  Maryland 20c. Location - City	10d. Inside City Limits 1 □ Yes 2X No  Country?  merican Indian,  hite, etc.  White ss/Industry  L Supply  cLain a, Zip Code) 21801 or Town, State
	Permit Department Depa	Examiner	4 Donation 5 Other (Specification) 21. Signature of Funeral Service Lice 23. Part. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications the cause one cause on each Due to (or a Due to (or a cause).	Parsons and the death. Do not have.	HOLLS Solve of Holls Solve on the Holls Solve of th	nd Addres Way E NOW F de of dying	e of Facility Unera Hill R	al HON Road, eardiac or re	me Prof Salisb	essional oury, Mary	Association Association Approximate Interval Between Onset and Death
Hecords, P.O. Box 68/60	e faw requires that the death certificate has been signed by the attending phys to 2 should be detached for use as the	Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of	4□Pregnant 9□ Unknown	2 Fetel death at time of death	3 □Ectopic p 5 □ Other (s the underlying	pecity)	n in Part I.		1 ☐ Ye 24a. Was ar autopsy perform	s 2 No 3 1	Day Year  to the cause of death?  Probably 4  Unknown  autopsy findings available of completion of cause of
sion of Vital H	ysicien: ils certific director,	To Be	25. Was case referred to medical examiner?  1  Yes				28c. Injury Work	or: 4 🗆 Nurs	sing Home 28d	Check only one	No 1 Y nce 6 □Other (S w injury occurred	
DIVISION	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical Certification:	(Check only 2 ☐ Medical Exar	building,  ysician: To the be	Injury - At home, far etc. (Specify) st of my knowledge of examination and	, death occurred	at the tim	e, date and inion, death	place, and	City or Town	, State)  use(s) and manner	Rural Route Number, as stated. lue to the cause(s)
1	To the within 2 To the complete	Med	29b. Signature and title of centifie	and manner			License	827	Sitte		d. Date signed (Mc	onth, Day, Year)
{·	Sta Registr		30. Name and address of person who 31418 WWW 31. Date filed (Month, Day, Year) NOV 19	terpla	f death (Item 23a) (	Type, Print) SY S	C 10	35	alis	shun	j, md	21804

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Α. Gooby 16, November 2004 /Medical 03:24 P. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's County Hospital Cheverly
If Under 1 Year I If Under 24 Hrs. Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Months 43 Yrs. Director 578-92-9160 7/15/1961 Wash.D.C. Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD P.G Fairmont Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Itams 23a 1007 59th Ave. 20743 U.S.A. death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 \( \text{Yes} \) 2 \( \text{No} \) 6 \( \text{27} \) 80 If Yes, Give Year or Dates: 6 \( \text{26} \) 84 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "neturel", or Ital 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) stems 12 Engineer 1 vate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Betty Jane Bolden Tilghman Gooby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr eny Injury or other treum QDG. 12652 Council Oak Dr. Waldorf, MD. 20601 Jane Jeter-Prince/cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 11/24/04 Cheltenham, MD. MD. Vet. Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service Licensee 3910 Silver Hill RD.Suitland,MD.20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cause (Final Cardiovascular Disease 40ertenscre Atheroscherotic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the ! IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 X Yes 2 □ No 1X Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME November 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 4 1- State Registrar/AMEND#19aperINF12/1/04, BMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Nov. 19, 2004 6:23 <u>Cleopatra Glakas</u> 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1 □ M 2√□ F 84 577.28.1226 Feb.29,1920 Waycross, Usual Residence of Decedent 10c. City, Town or Location Chevy Chase 10b. County 10d. Inside City Limits Montgomery 11 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #504 South 20815 USA 4515 Willard Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Pappadeas Stavroula Alexopoulos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 Willard Ave. #504 South, Chevy Chase, MD20815 John J Glakas / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, MD Nov.22,2004 Parklawn Cemetary <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility oseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee William K. 5130 Wisconsin Ave. N.W., Washington, D.C. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf Acute Subarachnoid disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, any, sading to immodute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? an ticoago laten 1 Yes 2X No 3 Probably 4 Unknown 24a. Was an

/Medical Examiner

Physician

**Physician** 

/Medical

**Examiner** 

10a, State

MD

Director

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Completed

**Funeral** 

Director

item 27 is marked other than "naturel", or Itama 23a or 28a-f show other treumatic event, the Medical Examinar must be motified at

d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other treum

the Maryland

ed by the attending physician and detached for use as the burial-transit

Hospitet or Attending 24 hours after death. Director To the Hospitet of within 24 hours at To the Funeral D

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1□ Yes 2X No 26. Place of Death (Check only one)

28d. Describe how injury occurred

20814

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

3 Suicide

29a. Certifier

4 Homicide

5 Pending 2 Accident investigation 6 Could not be 28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stafed. (Check only one) 29b. Signature and title of perfilier

29c. License numbe 100

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Rd., Bethesda, MD

Allen Nimetz, M.D.

NOV

32. Registrar's Signature

State

Registrar

mended,1 & 1	18	State of Maryland / Dep State of Maryland / Dep State M.D./F.H.,TCHD,12/03/04,sbb	artme	ent of H	lealth a	and Me	ental Hy	giene Reg. N2	004	38881
Physician	1	1. Decedent's Name (First, Middle, Last)  Richard Jamart Holt Richard Ja					2. Date of De.	ath		3. Time of Death 7:15а м
/Medical Examiner		Aa. Fecility Name (If not institution, give street and number) Heartfields at Easton		ty, Town, or ston	Location o			4c. Co	unty of Death	
Funeral Director	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $170-24-2520$ 1 $^{\circ}$ M $^{\circ}$ 2 $^{\circ}$ F 85 Yrs.		der 1 Year is Days	If Under : Hours	24 Hrs. 8	B. Date of Birt (Month, Da 1 2 - 20 -	h y, <i>Year)</i> -1918	9. Birth Cor PA .	nplace (State or Foreign untry)
aryland show		Usual Residence of Decedent         10c. City, Town or           10a. State         10b. County         10c. City, Town or           MD         Talbot         Easton	Location							10d. Inside City Limits  Yes 2 □ No
with the Me or 28e-f	-	10e. Street and Number 700 Port Street	10f.	Zip Code 21601	1	-		10g. Citizer USA	of What Co	untry?
d 21215-0036 filed with in Maryland filed within 72 hours after death with the Maryland Hygiene.  Hygiene, then "naturel", or Items 23e or 28e-1 show ant, the Medical Examiner must be multibut at the Completed by Funeral Director		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 No If Yes, Give		cedent of H pecify Cuba 2 XNo	ispanic Origin, Mexican	gin? (Spec , Puerto R	ify Yes or No ican, etc.)		Race - Amer Black, White ecify: Wh	e, etc.
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours aft if Health and Mental Hygiene. item 27 is marked other then "naturel", or other treumatic event, the Medical Expra To Be Completed by F		(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	re kind of DO NO	sual Decup work done of use retired	during mosi d)	t of working	g		of Business/l	,
and 21 d be filed wontal Hygie ced other t	3	12 years   4 years   Muse 17. Father's Name (First, Middle, Last) John Paul Holt, II	eum_	Direc	18. Mothe	r's Name	(First, Middle,	Maiden Su		Museum
Marylanc ad 2 should be f th and Mental I 27 is marked of rtreumatic eve		19a. Informant's Name/Relationship (Type, Print) Marjorie Holt (wife)  19b. Ma	iling Addı Chad	ess (Street a Wick	and Number Teri	or Rural Cace	Route Number	er, City or To	own, State, Z Md . Z	(2 Code) 2 1 6 0 1
Baltimore, partition of the partition of	0.770	20a. Method of Disposition  1 Burial 2X Cremation 3 Removal from State  4 Donation 5 Other (Specify)	position (	Name of Prother place EMa C	3ry 1		2-2004	20c. Locat 4 Dov	ion-City or er, [	Town, State DE •
Baltimore pernit. Pages 1 Department of F Importent: If its any njury or ot	I	21. Signature of Funeral Service Licensee	22. Name R • C	and Addres	ss of Facilit	urle:	y Fune	eral	Home,	PC 21663
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition and condition				cardiac or	respiratory a	rrest,	,	Approximate Interval Between Onset and Death
/Medical Examiner		Du to (or as a consequence of):	den	nent	ia					15years
760, tte be executed systician and ne burial-transit tcal Examiner	3	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			_					
Box 68 sath certifica attending pt for use as th			B⊟Ectop	c pregnancy (specify)	1			230	. Date of deli Month	ivery Day Year
rds, P.O. uires that the de signed by the iid be detached	2	Part II. Other significant conditions contributing to death but not resulting in the	undertyi	g cause giv	en in Part I				contribute to	the cause of death?
Division of Vital Records, to the Hospital or Attending Physician: The law requires I within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	Para la la la la la la la la la la la la la						24a. Was autop perfo		24b. Were au prior to death? 1  Yes	topsy findings available completion of cause of 2 No
hysicien his certification I director	ן כ	25. Was case referred to medical examiner?  1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3		ier: Nu		(Check only only only only only only only only		Other (Spec	cify)
Division o set of Attending Pl s after death el Director: After th ed in by the funera		27. Manner of Death  1 Matural 5 □ Pending (Month, Day Year)  2 □ Accident investigation  3 □ Suicide 6 □ Could not be	М	1.	yat k? Yes 2□	No	8d. Describe			ıral Route Number,
Divi		4 Homicide determined 286. Place of injury - At nome, fam, building, etc. (Specify)					City or To	wn, State)		
o the Hospi thin 24 hou o the Funer impletely fill	בתוכם	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, de additional examiner: On the basis of examination and/or and manner stated.	investiga	ion, in my o	pinion, dea	id place, a th occurre	nd due to the d at the time,	date and pla	ace, and due	to the cause(s)
To T with To L	IV.	29b. Signature and title of certifier A. Frsiker, MD		29c. Licens	ZZS	7		29d. Date s	3/04	h, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type Matthew J. Fischer, MD 2 Mart:		ourt,	Eas	ston,	Md.	2160	1	
State Registrar		21 Data filed (Month Day Vear) 22 Benistrar's Signature	rest			•				

DHMH 17 Rev 1/2001

( 1	, •		1 - For State Registrar Amended it	State of Maryla :em# 1 11-19-	and / Do	epartme Ra <i>ntific</i> a	ent of Hea ate of De	alth and eath	Mental Hy	giene	004	38882
	Die et et		1. Decedent's Name (First, Middle, Last	9					2. Date of De		Vara	3. Time of Death
	Physicia /Medic		VIRGIL Vir	gil Franklin	Horn	e Jr.	110	RNG	Month	Day	6 700	118:00 PM
}	Examin		4a. Facility Name (If not institution, give	street and number)		4b. C	ty, Town, or Loc	ation of Deal	h	4c. Co	unty of Death	
			The Johns Hop	Kins Hospi	tal	P	1/2 May	œ ( <u>`</u>	ty			
	Funeral Director		5. Social Security Number 6. Se	7. Age (Iñ y) 2XM 2□ F 40	rs. last birth Yı	Monti		Under 24 Hrs lours Min.	(Month, Da	ay, Year)	9. Birth	place (State or Foreign intry)
-			222-64-3586 23	40		-			10-07-	-1964	D	elaware
	yland		10a. State 10b. County	10c.	City, Town	or Location						10d. Inside City Limits
	Be-fs	ctor	Delaware Sussex	S	eafor	đ						1 ☐ Yes 2\(\bar{\}\) No
	or 26	Funeral Director	10e. Street and Number			10f.	Zip Code			10g. Citizer	of What Cou	intry?
	ath w	ral	30330 Oak Grove R				.9973			US		
	er de Items	une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was De	cedent of Hispar pecify Cuban, M	nic Origin? (S lexican, Puer	specify Yes or No to Rican, etc.)	)- 14.	Race - Ameri Black, White	
38	irs af	by	3 Widowed 4 XDivorced	1 ☐ Yes		1 🗆 Yes	2IXNo Sµ	pecify:		Sp	ecity: wh	ite
21215-0036	within 72 hours after death with the Maryland ene. Then "neturel", or Items 23a or 28e-f show ne Modical Examiner must be notified at	ted	15. Decedent's Edu		16a. C	ecedent's U	sual Occupation	1		16b. Kind	of Business/Ir	ndustry
7	thin 7	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	- 7	ife. DO NO	work done durin use retired)	g most of wo	rking	Amer	icans	with
	ed wi	Completed		2		Lobby					biliti	es
and	be fill tal H od oth	Be	17. Father's Name (First, Middle, Last)				18.		me (First, Middle		mame)	
<u> </u>	d Mer narke natic	ပ	Virgil F. Horne Sr  19a. Informant's Name/Relationship (T)		405.1	4-1P- Add	101		e Wilke			
Maryland	d 2 s th an t7 ls i		Arline Horne - mot						ural Route Numb Seaford,	-		o Code)
	Heal Heal other		20a. Method of Disposition		. Place of D	isposition (/	lame of		Date		ion - City or T	own, State
E	Pages ent of nt: If i		1 XBurial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)				r other place) h Cem.	11-	22-04	Seaf	ord, DE	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if time 27 is marked other than "neturel; or frems 23a or 28e-1 show eny injury or other traumatic event, it a Modical Examiner must be notified at once.		21. Signatur of Fu eral Sovice Licens	4	_		and Address of		-			
m	permi Depar Impo eny ir		John A. Cran	iston			ston Fu			10073		
			23a. Part. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the de	ath. Do no	t enter the m	ode of dying, su	ch as cardia	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. CFR	EBELL	AR	noron	RnA	rE			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of	:		, -, -, -, -, -, -, -, -, -, -, -, -, -,	-			
	_xuiiiiei	<u></u>	Sequentially list conditions, if any, leading to immediate	b. S6P7	70		ousm					GDDYS
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due 10 (01 as a cons	equence on							
Ć.	exect n and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a cons	equence of)	:						
68760,	icate be executed physician and s the burial-transit	dical		d								
89	ng ph	a)	IF FEMALE:									
Вох	death certifica attending ph d for use as t	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death	3 □Ectopio	pregnancy			23d.	Date of deliver	*
P.O.	the a	Physician/M	1 Yes 2 No	4□Pregnant at time of 9□Unknown	f death	5 Other	'specify)				WOTH	Day Year
٥.	res that the de igned by the a be detached f	Ph	Part II. Other significant conditions co	ntributing to death but not r	esulting in t	ne underlyin	cause given in	Part I.	23e. Did to	obacco use	contribute to t	he cause of death?
sp.	uires Isign Id be	d by										oably 4 DUnknown
00	w require s been si should b	Completed							24a. Was	an 2	4b. Were auto	ppsy findings available
Re	The lay te has age 2	omp							autop	osy rmed? _	prior to co death?	mpletion of cause of
ta	ysicien: The is certificate ha	BeC	25. Was case referred to medical				26.	Place of Dea	1 ☐ Yes ath Check on a	2 No	1 🗆 Yes	2LIN0
<u>-</u>	Physic this ce al direc	70 E	examiner? 1 Yes 2 No	Hospital: 1 Impatient 2	☐ ER/Outp	atient 3	OOA Other: 4	□ Nursing H	ome 5 Resid	dence 6 🗆	Other (Specif	(y)
0	ding Phy h. After this funeral o		27. Manner of Death  □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Tin Inju		28c. Injury at Work?		28d. Describe h	now injury oc	curred	
Sio	Attendi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 □ Yes	2 □ No				
Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm	, street, fact	ory, office		28f. Location (S City or Tox		umber or Rura	al Route Number,
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death, within 24 hours after death.  To the Funeriel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Phy	sician: To the best of my k	nowledge. d	leath occur	ed at the time da	ate and place	and due to the	cause(s) and	I manner as s	tated
	e Ho:	Medicai	(Check only 2 Medical Exami	iner: On the basis of examinand manner stated.	nation and/o	or investigati	on, in my opinior	n, death occu	rred at the time,	date and pla	ce, and due to	the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier	unag		2	9c. License nun			29d. Date si	gned (Month.	Day, Year)
	10		)\(\cdot\)	mal M.D.			RES -	000		NOVE	11/6U	16 4 2004
2	SM		30. Name and address of person	ompleted cause of death (It		pe, Print)						
			NEGRAT NAVI	32 Benistrar's Sin	naturo	NOLFE	STUBO	T, 1sm	TIMONE	M1)-	21287	7
	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 9	2004 Den	سمم	G	Spark	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** November 2004 Ina S. Hastings 0405 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbur Wiconico Minsula Kegional Med ICAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Social Security Number Date of Birth (Month, Day, Days Min. 1 □ M 2 🛣 F Months Hours 99 Director 217-44-1672 6-30-1905 Md. Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show item 27 is marked other then "neturel", or items 23a or 28e-1 show other treumatic event, the Madical Examinations to notified at 1X Yes 2 □ No Director Md. Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 900 Booth Street USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) t of Health and Mental Hygiene. If item 27 is marked other the Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be Joseph S. Carey Laura A. Jones Carey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Phillips, niece 425 Pine Bluff Rd. Salisbury, Md. 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If eny injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) Line Cemetery 11-19-04 Delmar, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove St. Delmar, De. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORDNARY ARTER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes E 140 Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 🗌 Yes 3 □ 400 Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation death. 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a Funerel I Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I 29c. License number NOVEMBER 16 2004 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY MD EASTERN B SHORE DRIVE 32. Registrar's Signature

Registrar

)

<sup>4</sup>8<sup>0</sup>2004

			For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	irtment of H tificate of I	lealth and N Death		gien <b>e</b> () () Reg. No.	4 38884
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	3. Time of Death
	Physicia /Medic		ARWILLA CONW	'AY HART				NOU		004 08:56 AM
	Examin		4a Facility Name (If not institution, give s		1	4b. City, Town, or	Location of Death		4c. County	
		н	Peninsula Regiona		enter	XU!	Shury		Wic	mia
	Funeral Director		<ol><li>Social Security Number</li><li>6. Sex</li></ol>	7. Age (In yrs	. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hys. Hours — Min.	8. Date of Bir (Month, Da Sept. 1:	y, Year)	9. Birthplace (State or Foreign Country) Maryland
	pu ,		Usual Residence of Decedent	100.0	ity. Town or Lo	antina				10d. Inside City Limits
	arylau show	_	10a. State 10b. County		,					1 ☐ Yes 2 📆 No
	Ba-f	Director	Maryland Wicomico	SA	LISBUR				40.00	
	with t		10e. Street and Number	1		10f. Zip Code			10g. Citizen of W	ŕ
	s 23	erai	535 N. Curlew Roa	2. Was Decedent Ever in	19 12 1	21801		acify Vas or No	USA 14 Bace	- American Indian,
ခွ	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Evarult at must be confilled at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 → No	Specify:	Rican, etc.)	Black Specify.	k, White, etc.
21215-0036	hour tural	pa pa	15. Decedent's Educ	Year or Dates:	16a Deced	lent's Usual Occun	ation		16b, Kind of Bu	
Ċ	filed within 72 Hygiene. other than "na's ent, the Wedle	Completed	(Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of work	ring		er County
712	filed withi Hygiene. other than ent, the M	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Teach	er				f Education
	Hyg other	BeC	17. Father's Name (First, Middle, Last)		1.		18. Mother's Nam	e (First, Middle	Maiden Sumam	9)
<u>a</u>	should be nd Mental marked c	To B	JAMES ALLEN	I CONW	AY, SR.		IRENE		V	VRIGHT
Maryland	2 shou and M Is mar aumat		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Street	and Number or Rui	al Route Numb	er, City or Town,	State, Zip Code)
	s 1 and 2 should if Health and Men Item 27 is marke other traumatic		Maeve Hart-Morton/		23253	Adkits I	load - Sa	lisbury,	Maryland	21801
altimore,	of He		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date	20c. Location -	City or Town, State
Ĕ	Pages ment of ent: If It ury or o		'4 ☐ Donation 5 ☐ Other (Specify)	S		Memory				Maryland
Ball	permit. Pages Department of I Importent: If Ite eny injury or o' once.		21 Signature of Funeral Service License	1 Jaller		. Name and Addres				- Salisbury, MD 21801
ш			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
1	Pnysician :		Immediate Cause (Final disease or condition	ATHEROSCUE	ROTIC	CARDIO	VASCULA	AR D	HSEASE	Onset and Death
0	/Medical Examiner		resulting in death)	Due to (or as a conse					,	
		ner	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying	Due to (cr as a conse	iquanca of).					
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events							
Š,	oe execian a	E	resulting in death) Last	Due to (or as a conse	quence of):					
8760,	cate b	dical	d							
9 ×	iji ga	00 1	IF FEMALE:	3c. If yes, outcome of preg	nancv				22d Date	e of delivery
Box	death certifi. e attending I ad for use as	ian	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3 □	Ectopic pregnancy Other (specify)			Mor	,
o.	0 0 0	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown		2 0 11101 (0,000.1)/				
<u> </u>	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	by Physician/M	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contr	ibute to the cause of death?
S	quires n sign							10	Yes 2□No	3 ☐ Probably 4 ZUnknown
00	aw require s been si 2 should l	Completed						24a. Was	an 24b. V	Vere autopsy findings available rior to completion of cause of
æ	hysicien: The lav his certificate has I director, page 2 :	E						auto perfo	ormed?   d	eath?
ta	en: rtifica tor, p	0	25. Was case referred to medical				26. Place of Dea			
>	Physicien: rthis certifica ral director, p	To B	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	er: 4 Nursing H	ome 5 🗆 Resi	dence 6 Othe	er (Specify)
0	D = 0		27. Manner of C ath 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occurre	ed
0	endir eath. or: A	catio	2 ☐ Accident investigation			M 1 🗆	Yes 2 □No			
Division of Vital Records,	el or Att safter de l Direct d in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location ( City or To	Street and Numbe wn, State)	er or Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier Check only one) Cartifying Phys	sician: To the best of my keer: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mad date and place, a	nner as stated. ind due to the cause(s)
	vithin omple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
!	->-0		Muholas / 19	g been	w,	7	24592		11/12	1/04
			30. Name and address of person who de	mpleted cause of death (It	em 23a) (Type,	Print)	17010	1		
_			Nicholas Ogbu	10 100 E.	Carro	11 St.	Salisbu	14 N	10 21	801
	Sta		31. Date filed (Month, Day, Year) NOV 1 8 20	32. Registrar's Sig	nature &	Spark	34593 Salisbi V	/		
	Registi	ar	MOA TO TO	//		//				

220-26-9168

Arwilla Hart

			1 - For State Ragistrar	State of M	Marylan	d / Depa	artment of tificate of	f Health a	and M	ental Hyg	giene 0	04	38885	
	Physicia /Medic	al	1. Decedent's Name (First, Middle,  OLA HARR 4a. Facility Name (If not institution,	NGTON	or)		Ab City Tour	n, or Location	of Death	2. Date of Dea Month	16	Year OH ty of Death	3. Time of Death 1230 M	ı ——
	Examin Funeral Director	er	SHOCK TA 5. Social Security Number 218-01-2509	AUMA C	ENTE Age (In yrs. I	A last birthday) Yrs.	If Under 1 Ye Months Da	MOR ear If Under	E	8. Date of Birth (Month, Day MAY 21		9 Birtho	olace (State or Foreign ntry) 'LAND	า
	ne Maryland 8e-t show	ector	Usual Residence of Decedent  10a. State 10b. County  MD CARO	LINE		y, Town or Lo	LSBURG						10d. Inside City Limits 1X Yes 2 ☐ No	
	death with the ms 23a or 2 cmust be no	neral Dire	123 BLOOMINGDA  11. Marital Status	12. Was Decede		S. 13.	10f. Zip Cod 216	532	igin? (Spe	cify Yes or No-	10g. Citizen of US	SA ice - Ameri	can Indian,	
-0036	72 hours after death with the Maryland neture!; or Items 23s or 28e-t show disal Exactions must be notified at	Completed by Funeral Director	1 Never Married 2 Marrie 3 Widowed 4 Divorced  15. Decedent'	If Yes, Give Year or Date	No		1 Yes, specify to 1 Yes 2 to 2 to 2 to 2 to 2 to 2 to 2 to 2 t	No Specify:		Hican, etc.)		ack, White, ify: WH]	TE	_
21215-0036	ed within 72 ygiane. ner than "ne it, the wedin	Complet	(Specify only highest Elementary/Secondary (0-12)	College (1-40	or 5+)	(Give	kind of work do DO NOT use re SECRETA	ne during mos tired)			PROF	PANE		
Maryland	should be fill nd Mental H i marked oth	To Be	<ul> <li>17. Father's Name (First, Middle, L</li> <li>HARRY HARRINGT</li> <li>19a. Informant's Name/Relationsh</li> </ul>	ON		19b. Mailir	ng Address (Str	L	UCY (	(First, Middle, CHANCE I Route Numbe			Code)	
	Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ent: if item 27 is marked other than "neturel; or items 23a or 28e-1 show ury or other treumatic event, the Medical Examinat must be notified at		LINDA MOORE/NI 20a. Method of Disposition 13 Buriai 2 Cremation	3 □Removal from Sta	ite C	lace of Dispo emetery, crer	sition (Name o	f place)	D	NTON, MI	20c. Location	- City or To		
Baltimore,	permit. Page Department of Importent: If eny injury or		21. Signature of Funeral Service L			22	LL CEMI Name and Ac ELLOWS, 00 S. H	dress of Facili	ty	& NEWN EASTON,	EASTON AM FUNI MD 216			
	Physician Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. SPIN	h line.	040	er the mode of		cardiac o	r respiratory arı	rest,		Approximate Interval Between Onset and Death	
68760,	death certificate be executed  e attending physician and id for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, bearing to it modulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Que to (or	as a consequ	uence of):	CER	Reg L	HOVED BY	MEDICAL EXAM	INE A			
.O. Box 68	death certific e attending p ed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Feta t at time of d	Ideath 3	Ectopic pregna Other (specify				1	ate of deliver	ery Day Year	
S, P	signed d be de	by	Part II. Other significant conditio	_		ulting in the u	nderlying cause	given in Part	l.		bacco use cor		he cause of death?	1
al Record		Completed	CAUTROINTES	TINAL B	LEED						med? 2 No	Were auto prior to co death? 1  Yes	opsy findings available impletion of cause of 2 L No	,
of Vital	Physic this ce	n: To Be	25. Was case enerred to medicat examinat? 1 ☑ Yes 2 ☐ No 27. Manner of Death	28a. Date of I		ER/Outpatier 28b. Time o Injury		Othor	ursing Hon	(Check only or ne 5 ☐ Resid 28d. Describe h	lence 6 🗆 Ot		(y)	_
Division	itel or Attending I rs after death. rel Director: After led in by the funer	Certification:	1 Nataral 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be ned 28e. Place of building	04	1530 ome, farm, str		1 ☐ Yes 2 ☑	2	City or Tow	treet and Num		Al Route Number,  • ASTO  • ASTO	1
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical		Physician: To the be xaminer: On the basi and manner	s of examina		vestigation, in r			ed at the time, o		, and due to	o the cause(s)	
)	T with		30. Name and address of person v	who completed cause	of death (Item	n 23a) (Type.	22	1975			11/16	1		
	Sta	ate_	31. Date filed (Month, Day, Year)	AIR 2	2 S istrar's Signa	GRE	ene s	r (	BALT	MORE	MO	217	LOI	
	Regist	rar	MUA 18	AND CIERCE	a St.	Spil	AU.		_					

State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 18, 2004 **Physician** 5:20 P Semy Mimy HODAK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | Sept. | 23, 1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😾 F 69 506-56-1821 Director Morocco Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r then "neturel", or Items 23e or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6004 Durbin Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Å Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ith and Mental Hygiene.
27 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Restauranteur Restaurant 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) in and 2 should be fill Health and Mental High 27 is marked oth Be Hannah Bohbot Moshe Abesdris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $6004\ Durbin\ Road,\ Bethesda,\ MD\ 20817$ 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health at snt: If item 27 is rry or other treur. Marcel Hodak, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Importent: If eny injury or once. Mt. Lebanon Cemetery | 11/21/04 Adelphi, MD 1 4 □ Donation 5 □ Other (Specify) Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Carcinosarcoma of Ovary 11 Months disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last so the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the IF FEMALE esn If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 24a. Was an 1 Yes 2 X No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a To certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 ho To the Fun completely 1 (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 22775 November 19, 2004 m mg 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick G. Barr, M.D., 5454 Wisconsin Ave., #1300, Chevy Chase, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001 NOV 22

2004

			For State Registrar	St	ate of N	/larylan		artment of I					004	38887
			Decedent's Name (First, Midd	le, Last)				timodio or	Dodin	-	2. Date of Dea			3. Time of Death
	Physicia /Medic		Nina	5.		Ha	mel				Month NOV	17, a	lo O y	
	Examin	i	4a. Facility Name (If not institution	. 3		r)		4b. City, Town,	or Location	of Death			nty of Dea	
			HOLY CROS  5. Social Security Number	6. Sex		Ane (In vrs. I	last birthday)	If Under 1 Year	ILVER If Under		ENG 8. Date of Birt		NTGON	
	Funeral Director		229–36–7492	1 □ M :		74	Yrs.	Months Days		Min.	(Month, Day	y, Year)		irthplace (State or Foreign Country) EBRASKA
	P _		Usual Residence of Decedent			140.00						,		
	anylar show	ř	10a. State 10b. County			10c. City	y, Town or Lo							10d. Inside City Limits  ★□ Yes 2 □ No
	the M	Director	MD. PRING	CE GEOF	RGES			BERWYN H	EIGHT	S		10g. Citizen	of Mhos C	A
	with Se or	급		1 43777					00740			rog. Citizen		
	death ms 2;	Funeral	8816 621		as Deceder		S. 13.1	Was Decedent of f Yes, specify Cub	20740 Hispanic Or	igin? (Sp	ecify Yes or No-	- 14. F		nerican Indian,
9	after or ite	Fu	1 ☐ Never Married 2 XMar	rried 1	med Force: □Yes 2 <b>X</b> Yes, Give		1	ryes, specniy Cub 1 □ Yes 2 <b>X</b> □ No			Hican, etc.)		Black, Whi	ite, etc.
8	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show he Modical Examirer must be notified at	d by	3 Widowed 4 Divorce	d Y	ear or Dates	s:								WHITE
5	n 72 i	Completed	15. Deceder (Specify only highe	nt's Education est grade com			(Give	ient's Usual Occu kind of work done DO NOT use retire	during mos	t of work	ing	16b. Kind of	Business	s/Industry
21215-0036	withi iene. r then	mo	Elementary/Secondary (0-12)	C	ollege (1-4o	r 5+)		CLERK	•			DEP'T	. OF	AGRICULTURE
b	e filed of Hyg other vent,	Be C	17. Father's Name (First, Middle	Last)						er's Name	(First, Middle,			
Maryland	uld bu Menta arked	70 E	DEWEY		SPA	RKS				IV	MAR]	E W	ILLEY	Ž
Jar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neturel; or items 23e or 28e-1 show any injury or other treumatic event, the Modical Examiner must be notified at ones.		19a. Informant's Name/Relation					ng Address (Stree				_		· _ ·
e G	1 and Health em 27 ther t		CHARLES W. CF 20a. Method of Disposition	IAMBERS	S/HUSB		_ <b>8816</b> lace of Dispo	62nd sition (Name of	AVE.		RWYN HE]			20740 r Town, State
nor	ages ant of t: if it		1 Durial 2 Cremation 4 Donation 5 Other (		al from Stat	e c	emetery, crer	natory or other pla	1					
Baltimore,	nit. P vartme orten injur.		21. Signature of Funeral Service		1	CI	22	S CREMAT  . Name and Addre	ess of Facili	ty				E, MD.
ä	Dep Per Sun year		> 20/10/C	hain	lrus	<b>MOO</b> 0	091 C	HAMBERS 801 CLEV	FUNERA ELAND	AL HO	ME & CE	REMATO	RIUM,	PoA:7
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complication	ns that caus use on each	ed the death								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		12	rebra	L	nfarct						Onset and Death
	/Medical Examiner		resulting in death)		Due to (or a	as a consequ	uence of):							
l.		-	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b	Due to be a	is a consequ	ianga cifi:							
	uted Insit	Examiner	Cause (Disease or injury	<			33,100 017							
Ć.	execu in and ial-tra	Exa	that initiated events resulting in death) Last	С.	Due to (or a	is a consequ	uence of):							
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	dlcai		d										
9	ing ph	Med	IF FEMALE:											
Вох	leath certifi attending I for use as	ian/	23b. Was decedent pregnant	1	yes, outcom □Live birth	2 Fetal	death 3	Ectopic pregnanc	;y			T T	Date of de Month	olivery Day Year
<u>.</u>	that the de led by the a detached f	by Physician/Me	in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown		□ Pregnant □ Unknown		eath 5∟	Other (specify) _						20, 700.
۵.	that the by detail	y Ph	Part II. Other significant conditi	ions contribut	ting to death	but not resu	ulting in the ur	nderlying cause gi	ven in Part I		23e. Did to	bacco use co	ontribute t	to the cause of death?
Records,	quires n sigr uld be	q p									1 🗆 Y	es 2 □ No	3 □ P	robably 4 BUnknown
000	aw rec	plete									24a. Was a		o. Were a	utopsy findings available
	The I	Completed									autop: perfor 1 Tyes	med?	death?	completion of cause of s 2 \(\sum \) No
Vita	Physician: r this certifica ral director, p	Bec	25. Was case referred to medica examiner?						26. Place	of Death	(Check only or			
) t	hysio this co	2	1 ☐ Yes 2,X No	Hospit	1 Cunpa		EP/Outpatien	1 3 DOX			me 5 Resid			ecify)
UC C	Jing F	lon	27. Manner of Death  1 Natural 5 Pendi		a. Date of In (Month, D	Jay Year)	28b. Time of Injury	Wo	ryat irk? ]Yes 2.⊟		28d. Describe h	ow injury occ	urred	
Division of	Attending or death. ector: After by the tuner	Certification:	3 ☐ Suicide 6 ☐ Could	not bo	e. Place of I	njury - At ho	me, farm, str	eet, factory, office		-	28f. Location (S	treet and Nu	mber or R	lural Route Number,
á	al or A s after of Dire	Serti	4  Homicide	iniod	building,	etc. (Specify	")	,,,		Ш	City or Tow	n, State)		
	ospit hours unere ly fille		29a. Certifier 1 Certifyi	ng Physicier	: To the bes	of oversions	wledge, death	occurred at the ti	ime, date an	d place, a	and due to the c	ause(s) and	manner a:	s stated.
	To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funerel Director: After this certificate has been signed completely filled in by the tuneral director, page 2 should be de	Medical	one)	a	nd manner :	stated.	.on anworm			OCCUTT				
	To To	4	29b. Signature and title of certifie					29c. Licen:	se number o 6139	n	2	end. Date sign		th, Day, Year)
	9			1. 1	had as	I donath //s-	02-1/7		- UI / I	-		11/1	8/04	1
	1		30. Name and address of person		oo F	orest	Hein	DC C-	1001	Cari	as MI	١		
	Sta	te	31. Date filed (Month, Day, Year NOV 2		32. <b>P</b> /gis	trar's Signat	ture Z	Dr. Si	i UKV	7	71, 11	,		
	Registr	ar	NUV Z Z	2004	1		D	Spork	2					

			1- For State of Maryland / Depar	tment of Health and Me	ental Hygie	- NHHH 30000
	o		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		Kenneth Crawford Hayes	N	Month November	Day Year 17, 2004 12:10 p M
$\rangle$	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			3114 Gracefield Road #405	Silver Spring		Montgomery
П	Funeral		15™ 2□ E		B. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		Ian.20,19	15 Virginia
	yland			ation		10d. Inside City Limits
	a-f sl	ctor	Maryland Montgomery Silver	Spring		1 ☐ Yes 2 🙀 No
	or 28	Jire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath w	rai	3114 Gracefield Road #405	20904		USA
	er de	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was In Marital Status	as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	Dy F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes Corport State 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes or Dates:	☐ Yes 2√√ No Specify:		Specify:
21215-0036	72 hours after death with the Maryland Instural', or Itams 23e or 28a-1 show disal Exertine Trust be notified at	ted	15. Decedent's Education 16a. Deceder	nt's Usual Occupation	16b	White Kind of Business/Industry
215	hin 7.	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kii life. DC	nd of work done during most of working DNOT use retired)	7	, , , , , , , , , , , , , , , , , , , ,
2	ad wit	Com	5+ Manager	ment Analyst	Е	ederal Government
nd	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Maid	den Sumame)
yla	Men Men Marke Meric	2	Kenneth Crawford Hayes	Marian	Yancy	
Maryland	12 sh n and is m	1 3	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Address (Street and Number or Rural		
e, l	1 and Health am 27 ther t		Kenneth C. Hayes, Jr. Son 8641	Plymouth Road Ale		
Jor	or of its		1 X Burial 2 Cremation 3 Removal from State  1 A Removal from State  1 A Removal from State  Maryland Very Specific Companies of the Companies	tory or other place)	200	Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23e or 28e-f show may injury poother treumetic event, Itam Medical Examination and once.		'4 □Donation 5 □Other (Specify)  21. Signature of Funeçal Service Lice See	meteru Nov.22	, 2004 Che	ltenham, Maryland
Ba	Department any		Fr	Name and oddress of Facility ancis J. Collins F	uneral H	ome, Inc.
			23a, Part1, Enfer the disease, or complications that caused the death. Do not enter	University Blvd. the mode of dying, such as cardiac or	W., Silv respiratory arrest,	er Spring,MD 20901 Approximate
	Physician		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Chronic Obstructive Due to (or as a consequence of):	e Pulmonary Diseas	e	
Н	Examiner		Scolingia			
	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	and trans	Examiner	Cause (Disease or injury that initiated events c. Pue to (or as a consequence of):			
8760,	rate be executed thysician and the burial-transit	E	Due to (or as a consequence of):			
87	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d			
9 X	leath certifica attending ph	Physician/Med	IF FEMALE: 23b. Was decedent prognant 23c. If yes, outcome of pregnancy			02d Date of delivery
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No  23c. Wester to pregnant of Death o	ctopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
P.O.	at the death cert	hysi	9 ☐ Unknown			
	res that igned to be det	by P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rd	w require been sig should b		Chronic Renal Failure		1 ☐ Yes	2 No 3 Probably 4 □Unknown
000	e taw requ has been ge 2 should	plet	Anemia		24a. Was an	24b. Were autopsy findings available
m m	The ate has page	Completed	Hypertension		autopsy performed′ 1 ☐ Yes 2 🔀	
/ita	ysician: The is certificate hadirector, page	Be (	25. Was case referred to medical examiner?	26. Place of Death /		
<u></u>		မ	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	The second secon	5 Residence	6 ☐Other (Specify)
Division of Vital Records,	Attending Pher death. actor: After the	lon	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	d. Describe how in	jury occurred
isic	death death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	Lagation (Ctroat	and Number of Devil Devil Number
<u>&gt;</u>		ertification:	4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	t, factory, office	City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attenwithin 24 hours after deati To tha Funaral Diractor: completely filled in by the	0	29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death or	ccurred at the time, date and place, an	d due to the cause	(s) and manner as stated
	n 24 h	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investant and manner stated.	stigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifie	29c. License number	29d. [	Date signed (Month, Day, Year)
)	10		Som Aluchen	D 23649	Nov	vember 17, 2004
	(0		30. Name and address of person who completed cause of death (Item 23a) Type, Pri		1101	
			John Stuckey M.D. 106 Irving Stree	t, N.W. Washingt	on, D.C.	20010-2927
:	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature.	Soukes		
	ricgisti		1101 2 2007			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 0 0 4 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Charles Fay Hough, Sr. 18, 2004 November 1:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Northampton Manor Healthcare Center Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**M 2□F Min. Yrs. 215-26-1981 1923 West Virginia Director 80 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Motter Avenue, Apt. 501 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No White Specify: δ 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Painter</u> Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Franklin Hough Lucy Viands 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Trapaso / Daughter 1534 Beverly Ct.; Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State November 18. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \*4 □Donation 5 □ Other (Specify) Resthaven Crematory 2004 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. once 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 art / Enter he disease of com shoot, or heart failure. It only Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory one cause or Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b. Examiner Due to (or as a consequence of) the attending physician and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 1 No or Attending Physician: 25. Was case referred to medical examiner?

1 
Yes 2 
No Be 26. Place of Death (Check only one) Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? uneral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Atter 1 Natural 5 Pendina М 1 ☐ Yes 2 ☐ No investigation death 2 Accident within 24 hours after death To the Funeral Director: completely tilled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of cert who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person AVE, Frederich MD2/70/ JAD 80 MO A212 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2 2004

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryla		artmeni rtificate			and M		giene Reg. No.		38890
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Wesley Taft							2. Date of Dea			3. Time of Death 3:55 P M
	Examir		4a. Facility Name (If not institution, give 5404 Sandy Point	Road		Princ	e Fr		lck			County of Death alvert	
	Funeral Director		5. Social Security Number 6. Sep 217 36 6885	7. Age (In yr.	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours		8. Date of Birt OCL Day	1908		lace (State or Foreign Tand
	a-f show	ctor	10a. State 10b. County Maryland Calvert	10c. (	Prince		eric	k				1	Od. Inside City Limits 1 ☐ Yes 2 ▼No
	th with the 23e or 28 ust be no	Funerai Director	10e. Street and Number 5404 Sandy Point	Road		10f. Zip	<sup>Code</sup> 0678				-	zen of What Cour nited St	•
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural, or items 23e or 28e-1 show any injury or other treumatic event, I'm Medical Exart are must be notified at ODGe.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ XIo If Yes, Give Year or Dates:		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	city Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specifyhite	etc.
21215-0036	I within 72 I jene. r than "nati the Medice	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 6th	cation e completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done di	urina most	of workin	g		nd of Business/Ind	
and	d be filed ntal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last) William Reese H.	-11	, -, -, -, -, -, -, -, -, -, -, -, -, -,				r's Name 7dia	(First, Middle,	Maiden		
Maryland	2 shoute and Me is mark eumatic	오	19a. Informant's Name/Relationship (Type	pe, Print)				nd Numbe	r or Rural	Route Numbe	r, City or	Town, State, Zip	
re, ≥	1 and Health tem 27 other tr		Loretta H. Berry - 20a. Method of Disposition		Place of Dispo	sition (Nam	e of	T		ince Fi		rick MD	
altimore,	Pages ment of ent: if i		1 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		cemetery, crei bury Ce	meter	y N	ov 19			Bars	tow Mary	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	90	22	2. Name and	Address	of Facility	Raus	ch Fune	eral	Home	
	Pnysician	0 1	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the de-	ath. Do not ent	05 Br er the mode	oome of dying	S IS.	Rd.	Port I	Repul rest, /	blic MD	20676 Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	La			0.100	calw	0.6	CACI	
, 0,	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse					0045				
68760,	ficate but physicial for the but the b	edicai											
P.O. Box	The law requires that the death certifit te has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pre Other (spe					2	3d. Date of delive Month	ry Day Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	ndertying ca	use giver	n in Part I.		23e. Did to			e cause of death?
al Records,		Completed								24a. Was a autops perform	ned?	24b. Were autop prior to con death?	psy findings available apletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatien	t 3 DO	Other			(Chack only or	-/	Other (Specify	1
ion of	ing After	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury	at	28	3d. Describe h			)
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	ify)					City or Towl	n, State)	Number or Rural	
	To the Hospital within 24 hours of the Funeral completely filled	edical	29a. Certifier (Check only one)  Check only one)  Check only one)	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred a restigation, i	t the time in my opi	, date and nion, death	l place, ar 1 occurred	nd due to the c d at the time, d	ause(s) a ate and p	and manner as sta place, and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	191		29c.	License	number	7 ~	2	9d. Date	signed (Month, L	Day, Year)
	1-	e same con	30. Name and address of person who con	mpleted cause of death (Ite	m 23a) (Type,	Print)	1)	2510	13		1 (	11-06	/
	4 Sta	0	Jonathan Lowen:	32 Registra Sign	nature			20678					
	Sta Registr	ar	31. Date filed (Month, Day Year) 1 8	3 2004 Elecu	as the	Sna	20						

			1 - For Amend Item 2	State of Maryland / per Dr., 6839	Department of I	Health and Mer Death	ntal Hygien	2004	38891
	Dhorie		Decedent's Name (First, Middle, Last)			2.	Date of Death		3. Time of Death
	Physici /Medi		TLORENCE	EVELYN	JACKSI		4 4 4	5 - 04	1730M
7	Examir	ner	4a. Facility Name (If not institution, give s	. 1	4b. City, Town,	or Location of Death	4	c. County of Death	
	· · ·		5. Social Security Number 6. Sex	7. Age (In yrs. last i	birthday) If Under 1 Year	ISBURY If Under 24 Hrs. 8	Date of Right	WICOM	
	Funeral Director			M 20 F 44	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Yea.	(Coul	place (State or Foreign
	P .		Usual Residence of Decedent				10-10	60	
	arylar show	-	10a. State 10b. County		own or Location				10d. Inside City Limits
	the M	Director	10e. Street and Number	D 2 F	ILIS BURY				1 Ves 2 No
	with Sa or	ă	00 -0	CTART	10f. Zip Code	7 ^ 1	10g. C	itizen of What Coul	ntry? ↑
	hours after death with the Maryland tural; or Items 23a or 28a-f show al Exarta we frout be reutified at	by Funeral	APT39 ~ TAYLOR	2. Was Decedent Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Specify	Yes or No-	14. Race - Americ	can Indian.
9	or Ite	Ŧ	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 ☐ No	If Yes, specify Cub	oan, Mexican, Puerto Rica	ın, etc.)	Black, White,	
5-0036	ural',		3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 □ No	Specify:		Specify: BL	ACK
15-	"nati	Completed	15. Decedent's Educ (Specify only highest grade		Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b.	Kind of Business/In	dustry
2121	within 72 ene. than "nai	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		,	Aus	mat Da	ca Dout
	Hygid other	BeC	17. Father's Name (First, Middle, Last)		ATAC FIUITI	18. Mother's Name (Fin	rst, Middle, Maide	n Sumame)	CH LHY CAKE
<u> a</u>	ould be filed with Mental Hygiene. <b>arked other tha</b> atic evant. Lea	To B	GEORGE H. L	VASHINGTON	)	FLARFANCE	ROOK	F CHR	ISTOPHER
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic evant. Ite Medical Exama arthural by routified at	. 3	19a. Informant's Name/Relationship (Ty)		9b. Mailing Address (Street	and Number or Rural Ro	ute Number, City		
	1 and Health em 27 ther tr		PEGGY WASHINGTO		173 HICKORI	4 MILLRD. F		MD 21	830
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other tr onca.		20a. Method of Disposition  ☐ Burial 2 Cremation 3 ☐ Re	emoval from State	of Disposition (Name of tery, crematory or other pla	Ce) Date	20c. 1	ocation - City or To	own, Stete
tim	permit. Pages Department of Important: If if any injury or o	1	4 □ Donation 5 □ Other (Specify)		ATDRY OF DEU	MARUA 11 23	104 D	ELMAR	DE
Ba	permit. Departr Importu eny inji	1	21. Signature of the ral Service License	fort-	22. Name and Addre	ess of Facility BEH	DIE ZI	MITH F	/ <del>H</del>
			23a. Part1. Enter the disease, or complic	ations that coused the death. Do	o not enter the mode of dvir	ABECCA ST.	DALISB spiratory arrest	URY, MD.	2180) Approximate
	Physician		Immediate Cause (Final	e cause on each line.	A	,	and an arrange		Interval Between Onset and Death
2	/Medical		disease or condition resulting in death)	Due to (or as e consequence	A105				Sycars
-5	Examiner		Sequentially list conditions						
	p ti	iner	Sequentially list conditions, any least 1 immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	e of):				
	and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	o of):				
8760,	icate be executed physicien and s the burial-transit	aiE		Due to (or as a consequence	9 01).				
687	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edlcai	d						
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy				23d. Date of delive	nry .
	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)	y 		Month	Day Year
P.0	at the de 1 by the a stached	Phy	9 Unknown						
	res tha igned I be det	þ	Part II. Other significant conditions con	ributing to death but not resulting	in the underlying cause giv	ven in Part I.		use contribute to th	
Ö	w require been signal	eted				II		. 12 No 3 □ Prob	abiy 4 □Unknown
Records,	has by	Completed		<del></del>			24a. Was an autopsy performed?	24b. Were autoperior to condeath?	psy findings available apletion of cause of
a			OF Was ages referred to medical				1□ Yes 2 1 No		2□ No
of Vital	Physicien: this certific ral director.	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1  Inpatient 2 ER/C	Outpatient 3 DOA Oth	26. Place of Death (Ch		. 500	
		-	27. Manner of Death		Time of 28c. Injur	y at 28d.	Describe how inju		)
io	2 2 4	atlo	1 Natural 5 Pending 2 Accident investigation	(MORRI, Day 19ar)		Yes 2 □ No			
Division	F 9 F C	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		ocation (Street a)	nd Number or Rura.	l Route Number,
Ω	oitel ours af								
	Hospitei 24 hours 2 Funerei I	Medical	29a. Certifier  (Check only one)  1 Certifying Phys 2 Medical Exemin	cian: To the best of my knowledger: On the basis of examination a	ge, death occurred at the tir and/or investigation, in my o	me, date and place, and oppinion, death occurred at	fue to the cause(s the time, date an	and manner as stored place, and due to	ated. the cause(s)
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Mec	29b. Signature and title of certifier	and manner stated.	29c. Licens			ite signed (Month, I	
	r s r ŏ		> merch			57359		-	
			30. Name and address of person who cor	npleted cause of death (Item 23a)		11237	7007	ember 16	204
			USHA NARESA			N ST. SA	USBURY	40 7/8	04
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1.5.01V1516	(			1
No.	Registr	ar	NOV 1 8 2004	Canada &	Apra Val				

ORIGINAL

DHMH 17 Rev 1/2001

B 191 State

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

GUNTA A. WHEELER M.D.

P.O.BOX 527

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONARDTOWN, MD. 20650

31. Date filed (Month, Day, Year) NOV 2 2 2004

32. R strar's Signature

Registrar

				partment of Health and Mertificate of Death		ene 004	38893
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Sandra Dee Jarvis		November 1	6, 2004 Year	1310 M
).	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Calvert Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Prince Frederick  If Under 1 Year   If Under 24 Hrs.		Calvert	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 1 M 2 F 41 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cou	place (State or Foreign intry)
	<u> </u>		Usual Residence of Decedent		April 15 19	963 Mary	land
	arylar show	_	10a. State 10b. County 10c. City, Town or Prince F)				10d. Inside City Limits
	the M 28a-f	ecto	Maryland Calvert Prince F1				1 Yes 2 XNo
	with Ba or	Funeral Director	850 Warner Drive	10f. Zip Code 20678	100	. Citizen of What Cou	•
	death ms 20	nera	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	United State	
စ္	or Ite		1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
800	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show Ite Madfed Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ ★ O Specify:		Specify: whit	æ
5	"nat	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	ing 16	b. Kind of Business/Ir	ndustry
12	iene. than than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	et Manager	т	J.S. Governme	
פַ	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		110
/lai	should be ind Mental s marked o umatic eve	To E	Lloyd D Mister	Patricia		Blevins	
Jan	2 sho			tiling Address (Street and Number or Rura			o Code)
e, N	1 and Health em 27			Amer Drive Huntingtown			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat, or Items 23a or 28a-f show amy injury or other traumatic event, the Marifield Examiner must be notified at once.		T DOS ME Z E O COMMENCO O EL COMPONENTO DE CALCO	rematory or other place)	Samo	c. Location - City or T	
ቛ	nit. Partme ortan injury		' 4 □Donation 5 □Other (Specify)  Asbury Cen  21. Signature of Funeral Sprvice Licensee	etery Nov. 19 2004 22. Name and Address of Facility	Bar	stow Marylar	rd
ñ	Depar Depar Impo any ir		1 DKCULOC	Raus	ch Funeral art Republic		
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	MO5 FTCOTIES IS. RO. PO enter the mode of dying, such as cardiac of	or respiratory arrest	. 110 20070	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Met a Station	C Breast	Cance		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	3			3 4000
h		4	Sequentially list conditions, and any, leading to immediate b. Due to (or as a consequence of).				
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury				
Ć	be executed sician and burial-transit	Еха	that initiated events c				
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d				
မ	artifica ing pt	0	IF FEMALE:				
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	B Ectopic pregnancy		23d. Date of deliver	ery Day Year
o	that the de ed by the a detached t	Physiclan/M	1 ☐ Yes 2 DNo 4 ☐ Pregnant at time of death 9 ☐ Unknown	Other (specify)		World	Duy Tour
σ.	res that the igned by be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
Records,	w requires been sign should be				1 ☐ Yes	2 No 3 Prob	ably 4 []Unknown
ဝ၁	e law requ has been je 2 shoul	Completed			24a. Was an	24b. Were auto	psy findings available
		Com			autopsy performed 1 Yes 2	prior to co death? No 1 \(\sum Yes\)	mpletion of cause of
Vital	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death			
	Physic this c	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EPVOutpati	The state of the s		e 6 Other (Specify	v)
on	tending P death. stor: After t the funera	tlon	27. Manner of Death  1 Another of Death  1 Another of Death  2 Accident investigation  2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time Injury		28d. Describe how i	injury occurred	
Division of	Attendi r death. ector: A by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Stree	t and Number or Rura	i Route Number.
	s afte	Certification;	4 ☐ Homidae building, etc. (Specify)		City or Town, S	tate)	
	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, a	and due to the caus	e(s) and manner as si	ated.
	To the Hos within 24 h To the Fun completely	Medical	and manner stated.				
	7 × 1		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
		-		D002/1189		111.04	
	20		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Zahir Vousaf MD Po Box	807 Prince Fre	derick 1	UN ONE	8
	Sta	e	31 Date filed (Month Day Year) 32 Pogistre Signature		NY ICE I	- 10 2001	0
	Registra	ar	NOV 1 8 2004 > Bloom &	Sparke			

			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of I		Mental Hy	giene	21 0	0001
			Decedent's Name (First, Middle, La	ist)				2. Date of De	eath	14 3.	Time of Death
	Physic: /Medi		PAUL F. KELMER					Month	Day 2.0	Year	4 5 3 M
	Exami		4a. Facility Name (If not institution, give	e street and number	)	4b. City, Town,	or Location of De	Nov	4c. County		15 AM
			Genesis Health	Care - 5	The Pines	Ea	ston		Ta	albot	
	Funeral		1 ' 1 ,	Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year Months Days			rth ay, Year),	9. Birthplace (	(State or Foreign
	Director		Usual Residence of Decedent		80 Yrs.			MAY I3	1924	NEW JER	
	land		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. In	side City Limits
	death with the Maryland ms 23a or 28a-f show rmust be notified at	ğ	MD TALBO	Г	EASTO	V					Yes 2 No
	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of V		
	13a o	O E	610 DUTCHMANS L	ANE		216	501		USA		
	death	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.			(Specify Yes or No erto Rican, etc.)		e - American Inc	dian,
9	after or ite		1 ☐ Never Married 2 💢 Married	Armed Forces'  1 XYes 2 If Yes, Give	No			erto Rican, etc.)		ck, White, etc.	
93	72 hours after natural', or ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 🗶 No	Specity:		Specify	WHIT	E
21215-0036	"natu	Completed	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occup kind of work done	during most of w	vorking	16b. Kind of Bu	usiness/Industry	
121	within iene. than *	m d	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retire	nd) -		CHART		D=D/TD
	Hygie Hygie other ant, II	ပိ	12 17. Father's Name (First, Middle, Last	0	O	√NER	19 Mothoda N	lame (First, Middle	SMALL		REPAIR
Maryland	ld be ental ked o ic eve	Be C	PAUL F. KELMER	,				INE REIC		θ)	
<u> </u>	2 shoul and Me is mark	2	19a. Informant's Name/Relationship (	Type Print)	19h Mailir	ng Address /Street	1	Rural Route Numb		State Zie Code	
M	od 2 1th ar 27 is rtrau		IRENE E. ASPELL/I					D., EAST	•		"
ē,	of Health of Health if item 27 i		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	Date		City or Town, S	tate
Ę	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		CHESAPEAK	natory or other pla E. CREMATI	· 1	11-25-20	04 STEVE	NSVILLE	. мп
Baltimore	그 든 뿐 글		21. Signature of Funeral Service Licer		22	. Name and Addre	ess of Facility				
ä	Depa Impo any ir		Doseph m. Os	Prousts C.	PSO FI	ELLOWS, H	HELFENBE	IN & NEWI T EASTON	NAM FUNE	RAL HOM	E PA
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do not ent	er the mode of dyir	ng, such as card	ac or respiratory a	rrest,	Appre	oximate
	Physician	8 .	Immediate Cause (Final disease or condition	One cause on each	sall to	. 110	A. 1.11.	12)			val Between et and Death
	/Medical		resulting in death)	aDue to (or as	consequency of):	VY PVI	1 3	11	/	1 da	7)
	Examiner		Sequentially list conditions	200	m. feve	della	me Z	16 V1	ment.	a La	arl
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or s	a consequence of:		Ol of the World				
	and and trans	Examiner	that initiated events resulting in death) Last	c							
8760,	icate be executed physician and the burial-transit	E		Due to (or as	a consequence of):						
		dlcal		d			-				_
×	death certific e attending p id for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						
Вох	atter for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)	У		23d. Date Mor	e of delivery nth Day	Year
o.	0 00 0	ıysı	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	32	Other (specify)					
σ.	₽ B		Part II. Other significant conditions of	ontributing to death b	out not resulting in the ur	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contri	ibute to the cau	se of deat
Records,	quires n sign	ed by	)./	n. 1	1/12	2		101	Yes 2□No	3 Probably	4 nknown
00	tw require s been sign should b	lete		/	11			24a, Was	an 24h W	Vere autoney fin	idinge available
Re	The tav ate has page 2	Completed			-			autor perfo	osy pirmed? d	Vere autopsy fin rior to completio eath?	
		a	25. Was case referred to medical	-			26 Place of D	1 ☐ Yes eath (Check only o		☐Yes 2☐N	lo
<u> </u>	Physician: this certific ral director,	OB	examiner?	Hospital:	ent 2 ER/Outpatien	3 DOA Oth	er /	Home 5 ☐ Resid		or (Specific)	
		T:U	27. Mann Death	28a. Date of Inju (Month, Da	ry 28b. Time of	28c. Injur Wor			now injury occurre		
0	Attending r death. sctor: After by the funer	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	<i>y Year)</i> Injury		Yes 2 □ No				
Division	or Attendate death Director.	Certification:	3 Suicide 6 Could not be determined	200. Place of Inj	ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (S City or Tow	Street and Numbe	r or Rural Route	e Number,
	ital o	Ce						1			
	the Hospital or nin 24 hours afte the Funeral Dire npletely filled in t	edical	(Check only 2   Medical Exam	illiner: On the basis o	of my knowledge, death f examination and/or inv	occurred at the tin	me, date and place	ce, and due to the courred at the time.	cause(s) and mar	ner as stated.	31150(5)
	분 등 분 요	Med	one)  29b. Signature and title of Contifue	and manner sta	ated.						
	To To	_		10	MO	29c. Licens	T7(7)	'	29d. Date signed	(pronth, Day, Y	ear)
•			20 Nome and add			De	1/10		11/24/	04	
			30. Name and address of person who are ROBERT B. SANC			,	FA STON	MD 21601	c.	/	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	LU EVE.	TEOTON,	TID 21001			
	Registr		NOV 2.9 20		A An	N.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12 **Physician** 2004 2:30 AM KATHRYN VIRGINIA KILMON /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner Somerset McCready Men, Hospital/Tawes Nursing Home Crisfield If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Days Hours 1 □ M 2 K F 2-13-1917 Yrs West Virginia Director 226-58-8790 Usuel Residence of Decedent pernit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flems 22s - 100. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County cr is marked other than "natural", or items 23a or 28a-f show rtraumatic event, the Madical Examiner must be notified at Yes 2 No Onley Funeral Director Accomack Va 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number U.S.A. 23418 PO Box 474 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaking Homemaker 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Leona Virginia Huffman Charles G. Frye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PO Box 474, Onley, Va 23418
PO Box 280, Melfa, Va 23410 19a Informant's Name/Relationship (Type, Print) Gerald W. Kilmon Vonda K. Doughty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation S □ Other (Specify) 12/5/04 Belle Haven, Va Belle Haven Cemetery 21. Signature of Funeral Service Licenses 22/Name and Address of Facility Doughty Funeral Home, Inc. PO Box 633, Exmore, Va. 23350 Approximate Interval Between Onset and Death 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on eech line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ASCVD \_\_\_miner Due to (or es a consequence of) Physician/Medical Examiner Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 Probably 4 Unknown URDSEPSIS Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? 2 No 1 ☐ Yes 2 ☐ No 1LI Yas Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20X No Medical Certification: To 1 patient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 48098 12/3/2004. Cristield, Md. 30. Name end address of parson who completed cause of death (Item 23a) (Type, Print) Howy Bijay grum bunathan

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 8 2004

32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registre 38896 Certificate of Death 2. Date of Death Month 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** РМ 25, 2004 GERALDINE LUCILLE KNOX NOVEMBER 2:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CUPPETT & WEEKS NURSING HOME OAKLAND GARRETT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F 219-14-5701 79 Yrs. 1925 MARYLAND Director 4, Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other fraumatic event, the Medical Expirit intel intellect at once. 1 ☐ Yes 2X No Directo GARRETT OAKLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 597 LYNNDALE ROAD 21550 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK DISTRICT COURT 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) PAUGH AMYIRENE JOHN WALTER ROWAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FRANKLIN J. KNOX - SON 211 N. FAIRFAX BLVD. RANSON, WV 25438 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State PLEASANT VALLEY CEM. 11/29/04 OAKLAND, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur o Funeral S Ance Licensee 22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550 M00167 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a athensclentic cardiovosculor 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intraediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy 2.X No 1 Tes or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 A ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death investigation Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and file of sertifier 29c. License number 00025759 November 25,2004 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 247 Accident MD21520 Walter K. MD 0 Neumann 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 29 2004 Registrar

DHMH 17 Rev 1/2001

1 - For State Registrar State of Maryland / Department Certificate	t of Health and Mental I e of Death	Hygiene 004 38897
Physician /Medical  1. Decedent's Name (First, Middle, Last)  Eleni Ioanni Kakoyianni	2. Date of Month Nove	Day Year
	Town, or Location of Death	4c. County of Death
	ewater	Anne Arundel
	Davs Hours Min. (Month.	Birth Day, Year)  9. Birthplace (State or Foreign Country)
Usual Residence of Decedent	3–3-	1918 Cyprus
10a. State 10b. County 10c. City, Town or Location Edgewate	er	10d. Inside City Limits 1 ☐ Yes 2 📉 No
Maryland Anne Arundel Edgewate	Code	10g. Citizen of What Country?
5 75 Tarragon Lane	21037	USA
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married 2 Married  1  Yes, specific Yes,	ent of Hispanic Origin? (Specify Yes or ify Cuban, Mexican, Puerto Rican, etc.) !∰ No Specify:	
The Never married 2 married 1 married 2 married 1 married 2 married 2 married 2 married 1 married 2 married 1 married 2 married 2 married 1 married 2 married 2 married 2 married 1 married 2 marrie	k done durina most of workina	16b. Kind of Business/Industry
College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)  Homemaker		Home
Toanni Hajipantela  19a. Informant's Name/Relationship (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Type, Print)  19c. Sophocles/ Daughter  15 King Co	18. Mother's Name (First, Mid Irini Papa)	
Toanni Hajipantela  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (	(Street and Number or Rural Route Number)	
Irini P. Sophocles/ Daughter 15 King Co	ourt, Annapolis, Ma	
20a. Method of Disposition  20b. Place of Disposition (Name cemetery, crematory or oth  1  Burial 2  Cremation 3  Removal from State  4  Donatign 5 Other (Specify)	e of her place) Date Cemetery 11-20-04	20c. Location - City or Town, State
20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  20b. Place of Disposition (Name cemetery, crematory or oth  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and  2973 SC	Address of Facility George P	. Kalas Funeral Home Edgewater, MD 21037
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.		y arrest, Approximate Interval Between
Physician /Medical Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Dewruta	Onset and Death 2 28
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.		
O D D D D D D D D D D D D D D D D D D D		
The second of the past 12 months?  1		23d. Date of delivery  Month Day Year
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The land of the property of th	use given in Part I. 23e. Di  1 [  24a. W au p   1   Yes  26. Place of Death (Check on)  Other: 4   Nursing Home 5 \( \text{Re} \) Re  c. Injury at Work?  1   Yes 2   Nov  office 28f. Location	Month Day Year  d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  as an topsy informed?  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  y one)  sidence 6 Other (Specify)
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Within 24 hours affect of the first of the f	use given in Part I.  23e. Di  24a. W au  26. Place of Death (Check onl)  Other: 4 Nursing Home 5 Re  c. Injury at Work?  1 Yes 2 No  office 28f. Location City or 1  t the time, date and place, and due to the n my opinion, death occurred at the time  License number	Month Day Year  d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  as an topsy informed?  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  v one)  asidence 6 Other (Specify)  he how injury occurred  (Street and Number or Rural Route Number, own, State)  (Street and Number or Rural Route Number, own, State)  1 29d. Date signed (Month, Day, Year)
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Within 24 hours affect of the first of the f	use given in Part I.  23e. Di  24a. W  24a. W  25c. Place of Death (Check onl)  Other: 4 \( \text{ Nursing Home } \) 5 \( \text{ Rec.} \) Rec.  Injury at Work?  1 \( \text{ Yes } \) 2 \( \text{ No.} \)  office  28f. Location City or 1  It the time, date and place, and due to the n my opinion, death occurred at the time.	Month Day Year  d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  as an topsy informed?  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  v one)  asidence 6 Other (Specify)  he how injury occurred  (Street and Number or Rural Route Number, own, State)  (Street and Number or Rural Route Number, own, State)  1 29d. Date signed (Month, Day, Year)

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		in	Decedent's Name (First, Middle	a, Last)			imouto	0, 2		2. Date of De		C U U 4	3. Time of Death	_
	Physic		Helen	Anna	Lil	listor	1			Month Novemb	Da	17,20	r	)
	/Medi Examir		4a. Sacility Name (If not institution					own, or l	Location of Deal			. County of De		_
			Peninsula Rec	unal Med	ICAL (	enter	0	al	Blurg			Wicon.	nica	
	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs.	. last birthday)	If Under 1 Months	Year Days	If Under 24 birs Hours Min.		th (v, Year)	9. Bi	rthplace (State or Foreign	1
	Director		Usual Residence of Decedent	10 M 2501	85	Yrs.				3/16/	191	9 N	ew York	_
	yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation		<del></del>				10d. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at ance.	ctor	Maryland W	icomico	Sa	lisbur	У						1 XYes 2 □ No	
	in th	Funeral Director	10e. Street and Number				10f. Zip C				10g. Cit	izen of What C	ountry?	
	s 23s	rai	200 Civic A					2180				USA		
	ter de	ū	11. Marital Status  1 ☐ Never Married 2 ☐ Marri	12. Was Deceder Armed Force ied 1 ☐ Yes 23	s?	J.S. 13.	Was Decede f Yes, specif	nt of His y Cuban,	panic Origin? (S , Mexican, Puer	Specify Yes or No to Rican, etc.)	-	<ol> <li>Race - Am Black, Wh</li> </ol>		
21215-0036	urs af	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates			1□Yes 2	X No	Specify:			Specify:	white	
2-0	72 ho	Completed	15. Decedent (Specify only highes	's Education		16a. Deced	lent's Usual	Occupat	ion	etrin -	16b. K	ind of Business	s/Industry	-
21	ithin nen	nple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT use	retired)	iring most of wo	rking	_			
21	ygler her th	S	12	4		Вос	kkeer						Office	_
and	iould be filed withli Mental Hyglene. Parked other than hatic event, I'le M	To Be	17. Father's Name (First, Middle, Jacob Reicl					1	_	me (First, Middle,				
Ž	should and Men amarke umaric	ြိ	19a. Informant's Name/Relationsh			10h Mailie	a Address (	Ctmatan	Anna		ter		7.0.11	_
Maryland	id 2 s ith an 27 is r traur		John J. Lill:		/son					ural Route Numbe				
	s 1 and 1 Health tem 27 other to		20a. Method of Disposition	ibcon bi.		Place of Dispo	sition (Name	of	OOII K	Date		cation - City or	ID 21863 Town, State	_
e E	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (St							/18/04		•		
Baltimore,	Departm Departm Importal any injui		ignature of Funeral Service I		Pu	22	. Name and	Address	of Facility	7 107 04	- Ja	TISDUI	. У, МО	_
ä	Depared Depared Important in suny irrespondent		DONAL SA. (W.	masor	CE	SP 5	0110v	vay	Funera Hill F	al Home Rd. Sa	Pr	ofessi bury M	onal Asso ID 21804	C
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the deat	th. Do not ente	or the mode	of dying,	such as cardia	or respiratory ar	rest,	our y jr	Approximate Interval Between	_
	Physician		Immediate Cause (Final disease or condition	40.		dive	Hoord	- t	ailur	0			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or a	as a consec	quence of):		, ,	0-00				Jears.	_
	Cxammer		Sequentially list conditions,	D		emi	<b>X</b> ·							
	ed sit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or s	a consec	1.0	1 do	N	disec	0.21				
	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or a			4 1-0	-)	00.340	-26	_	_		_
8760	ate be executed hysician and the burial-transit	calE		4										
68	ifficat g phy as the	edic		0.										
Вох	leath certifica attending ph for use as t	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			IT at an in area				1 2	23d. Date of de	livery	
Э.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant			Ectopic preg Other (spec				i	Month	Day Year	
P.0.	that the de led by the a detached	Phy	9 Unknown											_
S,	uires than signed I	þ	Part II. Dther significant condition	icusm.	but not res	sulting in the un	iderlying cau	se given	in Part I.				the cause of death?	
Records,	w requ	Completed	100/12/18/10	100031717						-	'es 2[		robably 4 Nonknown	_
<b>3ec</b>	has t	Idm	Dement	6		-				24a. Was a autop	SV	prior to	utopsy findings available completion of cause of	
a	iclan: The certificate ha			ius synd	cons					1 Tes	med? 2 No	death?	2 □ No	
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			- 7	Other:	-	th Check only or				
of	Phys or this oral di	H :	27. Manner of Death	28a. Date of In	jury	ER/Outpatient 28b. Time of		. Injury a	4   Nursing H	ome 5 Resid			city)	÷
ion	Attending F death. ctor: After y the funer	atloi	1 12 Natural 5 ☐ Pending 2 ☐ Accident investig		ay Year)	Injury	М	Work?	s 2 🗆 No		•,	,		
Division	after death after death Director:	lifica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of I	njury - At ho	ome, farm, stre	et, factory, c	office		28f. Location (S City or Tow	treet and	d Number or Ri	ural Route Number,	-
	Ital or rs afte ral Dii	Certification												
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	edical	Consect Only 2 medical c	Physician: To the bese examiner: On the basis	or examina	wiedge, death tion and/or inv	occurred at estigation, in	the time,	date and place	, and due to the o	ause(s)	and manner as	stated.	_
	thin 2 thin 2 mplei	Med	one) 29b. Signature and title of certifier	and manner s	stated.			icense n				signed (Mont		
	F 3 F 8		S.A. Reza	Jolali	MS				70610	5			12004	
			30. Name and address of person v	who completed cause of	death (Item	n 23a) (Tuno 5							1000	
				law 100 T	Sast	COXIC	Mst.	, Sa	spapon	, mD,	71	108		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1	32 Regig	trar's Signa	diture &	Sp	ak.	2					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. UUL Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 17:10 Monique M. Lee November 17, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Prince George's Cheverly Prince George's Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | January | 1975 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😾 F Yrs. 29 Director 577-94-5803 Washington, D.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Washington D.C. 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 4100 East Capitol Street, N.E. U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Domestic Engineer Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Michael M. Lee, Sr. Verilyn Waugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verilyn A. Lee (Mother ) 4569 Benning Road S.E. Apt. #303 Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Resurrection Cemetery November 26,2014 Clinton, Maryland 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. 20019 malisar 23a. Party: Enter r disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sprick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Arterioscianoti Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Respiratory Failure/vertilator Dependence 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? Anuxu Encephalopath Chusnic Ronal Failure Recurren this certificate 1 Yes 2/X/No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DD1852 November 18 2004 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queenshow Rd Hyothsville MD 20781 . DEVORENTO

Registrar DHMH 17 Rev 1/2001

State

	1	State Unpend Item	23a,27,2	waryland 28a-f p	er me	G839 1-1 rtificate of	3-05 ta	S INICIIIAI II	Reg. No.	04	38900
		Decedent's Name (First, Middle, L.)						2. Date of I		Year	3. Time of Death
nysicia: Medica		MARY CATHERINE	LOGAN						ber 27,		4:05 A M
xamine		4a. Facility Name (If not institution, g.	ive street and numb	ber)		4b. City, Town, o	r Location of De	ath	4c. Count	y of Death	
		Prince George's				Cheverl				e Geo	
eral	1		Sex 7. 1 ☐ M 2 🖾 F	. Age (In yrs. la	st birthday) Yrs.	Months Days	If Under 24 H Hours Mi	n. (Month, L	Day, Year)	Coun	
tor	-	212-84-3800 Usual Residence of Decedent		44	115.			Dec.	24, 1959	Wash	nington, DC
	⊢	10a. State 10b. County		10c. City,	Town or Lo	ocation				1	0d. Inside City Limits
	0	Maryland Prince	Coorgola	Din	erdale						1∭Yes 2□No
	Director	10e. Street and Number	George S	KIV	eruare	10f. Zip Code			10g. Citizen of	What Coun	itry?
		6021 67+h Azzania				2	0737		U.S.A.		
(	lera	6021 67th Avenue	12. Was Deced		. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or I	No- 14. Ra	ce - Americ	
	by Funeral	1 X Never Married 2  Married 3  Widowed 4  Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	! X No		If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	Specify:	erto Hican, etc.)	Speci	ick, White, o	
		15. Decedent's I		1	16a. Dece	dent's Usual Occup	ation		16b. Kind of E		
	Completed	(Specify onfy highest g	rade completed)	4005.)	(Give life.	kind of work done of DO NOT use retired	during most of w d)	vorking			,
	E	Elementary/Secondary (0-12)	College (1-4	40r 5+)	Unkr	nown			Unknow	m	
1	Be C	17. Father's Name (First, Middle, Las	st)				18. Mother's N	ame (First, Midd	le, Maiden Suma		
		David B. Logan					Marv M	. Gribbi	n		
1		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street				, State, Zip	Code)
		Ann Marie Blackw	ell - Sis	ster	7116	Lakeshor	e Drive	, North	Beach, M	aryla	nd 20714
		20a. Method of Disposition		00	ce of Dispo	sition (Name of matory or other place	(e)	Date	20c. Location	- City or To	wn, State
		1 ☐ Burial 2 🖾 Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		ate		an Cremato	1	1/2004	Alexand	lria	Virginia
once.	-	21. Signature of Funeral Service Lic		11001		2. Name and Addre			Funeral	Home.	P.A.
		1/ shuitte	171	0137		739 Balt					
	1	23a. Part1. Enter the disease, or co- shock, or heart failure. List onl	mplications that cau	used the death.							Approximate Interval Between
ı		Immediate Cause (Final			iooti						Onset and Death
n il		disease or condition resulting in death)	With the second	e Intox		JH					
1											
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	r as a conseque	ence of):						
	Examiner	Cause (Disease or injury that initiated events	C.								
		resulting in death) Last	Due to (or	r as a conseque	ence of):						
	dicai	,	d								
	ധ⊢	IF FEMALE:								1	
		23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Fetal o	death 3	Ectopic pregnancy			1	ate of delive	ry Day Year
	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Ynknown	4∐Pregnar 9□ Unknow	nt at time of dea vn	ath 5□	Other (specify)					
1	ج ا	Part II. Other significant conditions	contributing to dea	th but not resul	ting in the u	nderhing cause av	on in Part I	23e Did	tohacco use con	tribute to the	e cause of death?
	o l	Fait is. Other significant conditions	CONTINUE AND TO COM	an bat not 1030	ang in the di	idenying cause giv	on in raits.		Yes 2 No		abiy 4 □Unknown
	ted							-			
	Completed							24a. Wa	opsy /	Were autop prior to con death?	osy findings available npletion of cause of
	5							1 ☐ Yes			2□ No
1	n	25. Was case referred to medical examiner?	Hospital			Oth		eath (Check only	one)		
	0	tXXes 2 No	Hospital: 1 Inp			nt 3□ DOA Oth	4 🗆 Nursing		sidence 6 Ott		
	0	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Found.		28b. Time of Found	Wor		Zou. Describe	how injury occur	190	unk
	Certification;	2 ☐ Accident investigati 3 ☐ Suicide 6 🗶 Could not	11-27-	-04	3:05	A	Yes 2 XNo	28f Location	(Street and Numi	her or Dural	Boute Number
		4 Homicide determine	d building			eet, factory, office		City or To	own, State 602	1 67t	h Ave.
	<u>ا</u> د	CO- Co-distance of Continues		at hom							
9	_	29a. Certifier 1 Certifying F	Physician: To the bas aminer: On the bas and manne	is of examination	on and/or in	vestigation, in my o	pinion, death oc	curred at the time	, date and place,	anner as sta and due to	the cause(s)
	edicai	one)				29c. Licens	e number		29d. Date signe	d (Month I	Davi Varial
	edicai	one) 29b. Signature and title of certifier	11/ -			250. 250115	o marribor		200. Date signe	d (Month, C	Day, rear)
	edicai	one)	re Uhil	M		O.C.N					
:	Medical	one)	Ne Wull	of death (Item :	23a) (Type,	O.C.N			Novembe:		
	Medical	29b. Signature and title of certifier	re Yhul o completed cause A. Kar &		23a) (Type,	O.C.N	1.E.	. Baltin		r 28,	2004

State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month DECEMBER 2004 **Physician** 0210 LOUISE ELIZABETH LLEWELLYN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALLEGANY FROSTBURG VILLAGE NURSING HOME FROSTBURG If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 13 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** 10 M 2 F Days Hours Min MARYLAND 215 18 8673 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ral', or Items 23a or 28a-f show Examiner must be notified at XX Yes 2 No MARYLAND ALLEGANY FROSTBURG Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 HONEYSUCKLE LANE, APT 112 21532 U.S. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xio If Yas, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify δ 3 Widowed 4 Divorced WHITE "natural", Completed The Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) BOOKKEEPER/OFFICE/MANAGER LUMBER BUSINESS 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be WINTERED JONES CLARENCE LLEWELLYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other treu once. 316 ALLEGANY STREET, FROSTBURG, MD 21532 MILDRED SLEEMAN / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) FROSTBURG MEMORIAL PARK 12/4/04 FROSTBURG, MD 21. Signature of Funeral Service Licensee 60 W. MAIN STREET 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 rower s 7/60 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nonth disease or condition resulting in death) STA /Medical Dua to (or as a consequ ence of) **Examiner** a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit that initiated events The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as attending i IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No bed Division of Vital Records, P.O. the 9 Unknown 9 Unknown ģ signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 00 1 ☐ Yes or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25/No 1 Tyes 1 Inpatient 2 □ EB/Outpatient 3 □ DOA 2 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 1 Waturai Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after the Hospitel within 24 hours a To the Funerel C 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FROSTBURG PLAZA, FROSTBURG, MD 21532 -3 JESUS H. TAN, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment rtificate	t of H e <i>of L</i>	ealth a Death	ind N	lental Hy	/gien		l.	38902
	Physici /Medic		Decedent's Name (First, Middle, Last)     Thomas Lambis							2. Date of D. Month Nov • 1	eath .8, <sup>Dg</sup>	2004	Year	3. Time of Death 9:15 PM
)	Examir	er	4a. Facility Name (If not institution, give s Suburban Hospital				nesda	Location o			M	ontg	omer	
	Funeral Director		5. Social Security Number 6. September 577.48.6116	7. Ag	e (In yrs. last birthday) 82 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Feb. 19	192.	2.	9. Birthi Coul Gre	place (State or Foreign ntry) ece
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f ehow aumatic event, the Medical Examinating mult be neithed at	Funeral Director	MD         Montgome           10e. Street and Number         5913 Rudyard Drive		Bethesda	10f. Zip	Code )814				10g. Ci	itizen of W		10d. Inside City Limits 1
15-0036	72 hours after des natural, or itema colcal Examinar m	b	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade)		No 16a, Dece	f Yes, spec 1 ☐ Yes 2	No I Occupa	Specify:	, Puerto	ecify Yes or N Rican, etc.)			White,	te
Baltimore, Maryland 21215-0036	e filed within al Hygiene. I other than went, It a Ma	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5	Genera			ctor 18. Mothe	r's Nam	e (First, Middle	, Maider			Lon
Maryia	is 1 and 2 should be of Health and Mental item 27 is marked other traumatic even	2	Constantinos Lambi 19a Informant's Name/Relationship (Ty. Olga Lambis / Spou	ре, Print)				nd Numbe	r or Run	Vourde al Route Number thesda	er, City			Code)
imore,	Page Int: If		20a. Method of Disposition  13☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cometery, cren Gate of	Heave	her place en	N	ov.2	Date 3,2004	S		Spi	ring, MD
Ball	permit. Departrimports imports any inju		21. Signature of Furleral Service License	300		5130	Wisc	consi	n Av	eph Gav	., W			20016
	Physician /Medical Examiner		23a. Part   Pricer the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Sepsis  Due to (or as	a consequence of):		or dying	, such as	cardiac	or respiratory a	irrest,			Approximate Interval Between Onset and Death I - 17-04
8760,	death certificate be executed e attending physician and for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease u. irrjury that initiated events resulting in death) Last	Due to (or as	atic Sarcon a consequence of): a consequence of):	18								ınknown
O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pre						23d. Date Mon		ery Day Year
rds, P	ires tha signed d be de	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the ur	nderlying ca	tuse give	n in Part I.			tobacco Yes 2			ne cause of death? pably 4 □Unknown
al Records,	The ate h page	Completed								24a. Was auto perfo 1 Yes		pr de	ere auto ior to con ath? Yes	psy findings available mpletion of cause of
Division of Vital	Attending Physician: The death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner?  1  Yes  2  No  H  27. Manner of Death  1  Natural  5  Pending  2  Accident investigation	ospital: 1 <b>X</b> Inpatie 28a. Date of Injui (Month, Day	ry 28b. Time of		Bc. Injury Work	r: 4 □ Nur	sing Ho	n (Check only me 5 ☐ Resi 28d. Describe	idence			1)
DIVIS	i Qite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc						City or To	wn, State	ə)		l Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical	(Check only 2   Medical Examinates)	ner: On the best of ner: On the basis of and manner sta	of my knowledge, death examination and/or inv ited.	estigation,	in my op	inion, deat	l place, h occurr	and due to the ed at the time,	date and	d place, ar	nd due to	the cause(s)
3	5	«	29b. Signature and title of certifer  30. Name and address of person who co		SI CIAN	Н5	License			1		mber		2004
	Sta Registr	ite	Bradley J. Hunter, 31. Date filed (Month, Day, Year) NOV 2 2 200	M.D. 104	400 Connect	icut	Ave		6, K	ensing	ton,	MD	2089	)5

DHMH 17 Rev 1/2001

& Sports

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#5 per State of Maryland / Department of Health and Mental Hygiege 11StateFin.Dir. 11/23/04 BEM AACO. Health Certificate of Dooth Dept. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yaar **Physician** Lee 0815N 17 2004 oanne November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** HOOKINS Hospital Baltimore Johns | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 2, 1942 5. Social Security No.70 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2X F 62 MD Director 180-32-<del>2704</del> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 Is marked othar than "natural", or Itams 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Anne Arundel Severn MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1347 Ava Road 21144 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status if Health and Mental Hygiene.
item 27 is markad othar than "natural", or Itam
othar traumatic avent, it a Medical Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Novotny Della Nash ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1347 Ava Road, Severn, MD 21144 Walter Lee/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Nov. 18, = 5 permit. Page Department of Important: If any injury or once. Metro Crematory Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Facility 21. Signature of Funeral Privice Licensee Barranco & Sons, P.A. Severna Park Funeral Home

495 Cov. Ritchie Hwy, Severna Park, MD 21146

Approximate Interval Between Onset and Death

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Teukemia **Physician** Myelogenous WEEKS /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Tyes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home <sup>o</sup>L 1 ☐ Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation death. Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nolfe Street Baltimore 600 SHEN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Dav.

1 9 2004

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended, 26, per M.D., TCHD, 11/29/04 State of Maryland / Department of Health and Mental Hygiene O 38904 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11-23-2004 **Physician** Marion Clarke Marshall, Jr. 6:30 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Talbot Talbot Hospice House Easton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year 1 - 25 - 1925 9. Birthplace (State or Foreign St. Michaels 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F 78 218-16-7052 Director MD. Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exert incrimative to codified at Y☐Yes 2☐No St. Michaels MD Talbot Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 605 Meadow St. 21663 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 🛱 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced lf Y49s, Give Year or Dates: Navy 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Electrician 11 years
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be Marion Clarke Marshall, Sr. Lydia Denny Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sł Department of Health and Important: if Item 27 Is n any injury or other traum Roberta H. Marshall (wife) 605 Meadow St., St. Michaels, MD 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Capitol Crematory 11-24-2004 Dover, DE. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kenal tadure **Physician** /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burial-P.O. Box 68760, Physician/Medical the IF FEMALE: ase : 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ö in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ heart Taylune 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed Vascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed: 1 ☐ Yes 2 ☐ No certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice 6 Other Rouse Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 3 Aesidence 2

this After death. after death Director: in by

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 □ Could not be

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

Certification:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ussell a . Silie

29c. License number H42587 29d. Date signed (Month, Day, Year) 2004

gause of death (Item 23a) (Type, Print) 555 Cynwood Ar Baston Schilling 20 Kussell 1

31. Date filed (Month, Day, Year) NOV 29

32 Registrar's Signature

State Registrar

thin 24 hours a

2

State of Maryland / Department of Health and Mental Hygiene For State Registrar 38905 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0730AM 204 Victoria Matthews /Medical Dorothea 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cambridge

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Dorchester Mallard Bay Nursing Home 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 2ØF Director Jan. 22, 1921 83 Washington, D C 221-14-1514 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State "netural", or iteme 23a or 28a-f ehow adjeal Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo East New Market Maryland Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21631 USA permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene important: if Item 27 is marked other then "netural", or Iteme 23a any highry or other traumatic event, If a Medical Examiner master ADRS. P.O.Box 52 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurses Aide Mallard Bay 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Founcine Kelly ဂ္ Viola Jasper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Howard H. Matthews / Husband P.O.Box 52, East New Market, Maryland 21531 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-30-2004 Hurlock, Maryland Md. Veterans Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 516 S. Main Street, Hurlock, Maryland 21643 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Arch. 10 min **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 2 KON AL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy 2 Fetal death Month Day Year ŏ 4☐Pregnant at time of death 5 Other (specify) detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed director, page 2 certificate 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification; To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral ( 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide t 🔀 💏 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 26388 fallelu MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 302 Cellins Add en 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 = For State Registrar	State o	f Marylan		artment of H rtificate of L			giene Reg. No.	004	38906
	Physicia /Medic		Decedent's Name (First, Middle, L     Barbara	Brown Moo	ore				2. Date of De.	r 11, 2	2004 <sup>Year</sup>	3. Time of Death 5:36 A. M
	Examin		4a. Facility Name (If not institution, g Prince George's Hosp				,	Location of Death			ounty of Deeth	e's
	Funeral Director		213-44-6940	Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.	last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 28	y, Year)	9. Birthp Mary	lace (State or Foreign
e Maryland	a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince G	eorge's	10c. Cit	y, Town or Lo	estville			, -, .	1	0d. Inside City Limits 1XXYes 2 □ No
th with the	23a or 28	Funeral Director	10e. Street and Number 7605 Marion Street				10f. Zip Code	20747		10g. Citizer	of What Cour .A.	itry?
urs after dea	Department of Health and Mental Hygiene. Important: If Item 23e or 28e-f show Important: If Item 27 is marked other then "naturel", or items 23e or 28e-f show eny injury or other traumatic event, Ite Medical Examinar must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Fo	2 DNo ve	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, pecify: Bla	etc.
within 72 ho	ene. then "natur Le Medical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 12th grade			(Give	dent's Usual Docupa kind of work done of DO NOT use retired	during most of wor	king		of Business/Ind and Tra (Retir	demark Office
d be filed	ental Hygi ked other ic event, II	To Be Co	17. Father's Name (First, Middle, La Peter Br	•				18. Mother's Nan	ne (First, Middle, Gladys Th			
Maly nd 2 shou	ith and M 27 is mar r traumati	-	19a. Informant's Name/Relationship Mr. Ronald W. Moore	(Type, Print) (Husband)	)	19b. Mailir 7605	ng Address (Street a Marion Stre	and Number or Ru et Forestv	ral Route Numberille, Mar	er, City or Ti yland	own, State, Zip 20747	Code)
Pages 1 a	nent of Hea int: If Item iry or othe		20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		State C	cemetery, crei	osition (Name of matory or other place in Cemetery		Date er 18,200		tion - City or To	
parmit. Pages	Departn Imports eny inju		21. Signature of Funeral Service Lic	Ingle	sa	}	2. Name and Address	Р	ollins Fu Washingto		-	•
* I	nysician Medical		23a Pari1. Enter the disease, or co chock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on a	caused the deat each line. Ite Mycca (or as a consec	rdial Ir		g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Certificate be executed	physicien and stransit burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	oticemia (ur as a consect iration ) (or as a consect ltiple Sci	Preumni quence of);	а					
death death	e attending id for use a	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, ou	itcome of pregna birth 2 □ Feta nant at time of c	ancy	□Ectopic pregnancy			230	I. Date of delive	ery Day Year
OLGS, P.O	signed by d be detac	by P	Part II. Other significant conditions	s contributing to o	death but not res	sulting in the u	inderlying cause give	en in Part I.		obacco use		ne cause of death?
The law	ate has page 2	Completed							24a. Was autop pend 1 \( \text{Yes}	an 2 osy ormed? 2 🖾 No	24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 XNo
On OT VITAL	After this funeral di	tion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date (Mor		ER/Outpatier 28b. Time o Injury	f 28c. Injun World	er: 4 ☐ Nursing H	ath (Check only of lome 5 Residence 1 28d. Describe I	dence 6		y)
UIVISION al or Attending	ours after death. neral Director: After th filled in by the funeral	Certification:	3 Suicide 6 Could no 4 Homicide determini	ad 200. Flac	e of Injury - At h ling, etc. (Speci	ome, farm, sti fy)	reet, factory, office	-	28f. Location (: City or Tox		lumber or Rura	l Route Number,
he Hospits	within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 X Cartifying (Check only one)	aminer: On the	e best of my kno casis of examina nner stated.	owledge, deat ation and/or in	h occurred at the tin	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) ar date and pl	d manner as s ace, and due to	tated. the cause(s)
Total	Tott	Me	29b. Signature and title of certifier	Edun	M		29c. Licens	5 7.7		29d. Date s	igned (Month,	Day, Year)
7	4		30. Name and address of person wi				.Print) ne Capital H	Heights, N	Yaryland	20743		
	Sta Regist		31. Date filed (Month, Day, Year) NUV & # 2004	32.	Registrar's Sign	ature						

Records, Division of Vital or Attending

within 72 hours after death

Maryland 21215-0036

Baltimore,

Box 68760,

o.

Examiner the death certificate be executed within 24 hours af

To the Funeral Di

completely filled in **OCME** NOVEMBER 25, 2004 n M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ma 111 PENN STREET, BALTIMORE, MARYLAND 21201 31. Date filed (Month D 32. Registrar's Signature State Registrar ORIGINAL

			For State Registrar	State of M	arylan		artment of H		nd Mental H	lygiene Reg. No.	400	4 38908
	Physici /Medic	an	1. Decedent's Name (First, Middle ELLEN DEI	, Last) LORES MOREL	AND				2. Date of Month	Day	Yea -, 200L	7 65 M
	Examin	er	4a. Facility Name (If not institution WASHINGTON COU	JNTY HOSPITA	L		4b. City, Town, or  HAGERS  If Under 1 Year			W	County of Di	ION COUNTY
	Funeral Director		5. Social Security Number 233-84-1771 Usual Residence of Decedent	6. Sex 7. Ag	71	last birthday) Yrs.	Months Days	Hours	Min. 8. Date of (Month). April	$\overset{\text{Birth}}{26},\overset{\text{Year}}{19}$	933 W	Birthplace (State or Foreign Country) V
	Maryland	tor	10a. State 10b. County MD WASHIN	IGTON		y, Town or Lo					-	10d. Inside City Limits 1
	th with the 23a or 286	al Director	10e. Street and Number 13722 EMILY	STREET			10f. Zip Code 21740	)		10g. Citi	zen of What	Country?
980	72 hours after death with the Maryland naturelt, or Items 23a or 28e-f show Jical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ied 1 ☐ Yes 2 M If Yes, Give Year or Dates:			Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 X No		in? (Specify Yes or Puerto Rican, etc.)	No-	Black, W	merican Indian, hite, etc. NHTTE
21215-0036	d within giene. r than	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 5th		5+)	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired DMEMAKET	ation luring most )	of working	16b. Ki	nd of Busine Home	ss/Industry
Maryland	be do do eve	To Be C	17. Father's Name (First, Middle, DAVID HIGH	Last)			_		's Name (First, Midd ATHERINE			
	s 1 and 2 should f Health and Mer item 27 le marke other treumatic		19a. Informant's Name/Relations  LARRY STICKLI		1001 5	318 9	SOUTH LOCK		or Aural Aoute Nur	STOWN,	MD 2	21740
Baltimore,	0 0		20a. Method of Disposition 1 □Burial 2 □ Cremation 1 □ Donation 5 □ Other (S	pecify)	C	emetery, crer JAH HI	sition (Name of natory or other place GH CEMET)	ERY 12		PUR	GITSV	or Town, State
Bal	permit Pag Deparment Importent: I any in ury o		21. Signature Print al Service	Warner	k	23	BO E. MAIN	V ST.,	SHAFFER-V ROMNEY,	WV 2	6757	
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause of each li	ine.	Do not ent	ratory	1	Our			Approximate Interval Between Onset and Death
8760, 2	Medical Examiner  Assician and	lical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	a consequence	uence of):	buctin	o des	ny Xeis	eace		17 days
O. Box 68	the death certifics / the attending ph ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Idéath 3□	Ectopic pregnancy Other (specify)			_	23d. Date of o	delivery Day Year
Records, P.	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Ph	Part II. Other significant condition	ons contributing to death t	Tiles	ulting in the U	nderlying cause give	en in Part I.	1) 24a. W	Yes 2	□ No 3 □	o to the cause of death?  Probably 4 □Unknown  autopsy findings available to completion of cause of?
Vital	certifica rector, p	o Be Co	25. Was case referred to medica examiner? 1 ☐ Yes 2 7 → 10	Hospital:		5D/O-4	Othe	)E	of Death (Check on	ly one)	1  Y	
Division of	ng ftei	Certification; To	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	28a. Date of Injugation  28a. Date of Injugation  28a. Date of Injugation	ary Year)	ER/Outpatier 28b. Time o	28c. Injury	4 🗆 Nur		e how injur	y occurred	Rural Route Number,
Div	pitel or A burs after lerel Direc		4 Homicide determ	building, e	tc. (Specifi	y)		ne date and	City or	Town, State	)	
	To the Hospitet or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medical one)  29b. Signature and title of certifie	Examiner: On the basis of and manner si	of examina	tion and/or in	vestigation, in my op	oinion, death	h occurred at the tim	ne, date and	place, and o	onth, Day, Year)
	P S P O		30. Name and address of person	who completed cause of	death (Item	23a) (Type	D27	898		10	42/0	K
	St	ate	PRAN) CISCO A	OOKADE 32. Regist	30	MIL	A	HAGE	HS TORUN)	41	2174	0
	Regist		DEC 0 8	2004	neva	19	Long	1	•			

1 \_ State

MAN

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® Certificate of Death

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Approximate Interval Between Onset and Death

			Hegistiai					imout	00, 1	J - Cut., 1			Heg. r	NO.			
ı	Physici		1. Decedent's Nam	e (First, Middl ricia	e. Last) Dian	e M	McRoy					2. Date of D		Day	Year	3. Time o	
	/Medic							45 03	T. 33			Novemb			2004	0858	Α "
	Examin	er			n, give street and no					Location	of Death		'		y of Death		
					ventist Ho	ospital	•		wil					Mon	tgome	ery	
	Funeral		5. Social Security N	Number	6. Sex		s. last birthday,	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth You	ne)	9. Birth	olace (State	or Foreign
	Director		215-54	-5778	1 □ M 2 🕱 F	54	Yrs.	WOITEIS	Days	Hours	IVIII.	8. Date of B (Month, D Oct. 2	2.1	950	Cou	äryla	ınd
	D		Usual Residence of	f Decedent													
	/lan		10a. State	10b. County		10c. C	City, Town or L	ocation								IOd. Inside C	ity Limits
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-1 show the Modical Examilter in ust be multified at	ctor	MD	Mont	gomery		Ge	rman	towr	ı						1 <b>☐Y</b> es	2 🗆 No
	or 28	ire	10e. Street and Nu	mber				10f. Zip	Code				10g. (	Citizen of	What Cou	ntry?	
	after death wit or Items 23a o	Funerai Director	19364	4 Elde	rberry	Terr			20	876				Ţ	J.S.	Α.	
	ltems ner dea	ne	11. Marital Status		12. Was Dec	cedent Ever in	U.S. 13.	Was Deced	dent of Hi	spanic Or	igin? (Sp	ecify Yes or N Rican, etc.)	0-		e - Ameri		
9	or It	Ŀ	1 Never Marr	ied 2🔀 Mari	ied 1 ☐ Yes	2 [ <b>X</b> No	1					riican, etc.)			ck, White,	etc.	
03	72 hours a natural, o	d by	3 🗆 Widowed	4 Divorced	If Yes, G Year or I	Dates:		1 🗆 Yes	21 <b>-2-</b> No	Specify:				Specif	Bla	ack	
215-0036	"natu	iete	(Spec	15. Deceden	t's Education st grade completed,	)	(Give	dent's Usua kind of wo	rk done o	lurina mos	st of work	ing	16b.	Kind of B	usiness/In	dustry	
212	7 7 1	Completed	Elementary/Seco 12th		College	(1-4or 5+)		<i>во кот и</i> : Supe:		•			Н	ouse	ekee	ping	
D	be filed tal Hygie d other	മ	17. Father's Name	(First, Middle,	Last)					18. Moth	er's Name	e (First, Middle	. Maide	en Suman	ne)		
Maryland	Q 20 0	To B	Johr	1	Twyman						Luc	ille :	Sim	s			
a	d 2 should th and Mer 7 ia marke traumatic		19a. Informant's N	ame/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	and Numb	er or Rura	al Route Numb	er, City	or Town,	State, Zip	Code)	
IPs.	5 = N -				Daught		_1083	2 Bac	dger	Dr	Gai	thers	bur	g, M	1D 20	0877	
Š	item item		20a. Method of Dis	•	- 7-	20b.	Place of Dispo cemetery, cre-	sition (Nan	ne of ther place	e) i		Date	20c.	Location -	City or To	wn, State	
Ë	nit. Page artment o ortant: If injury or		1 □XBuriai 2		3 □Removal from pecify)	State	late 0	f Hea	aven	ı		22/04					
Baltimore	permit. Departr Importu any inj		27. Signature of Fu		License	1	1					owden					
	0.U ≥ € 0		1	GE K	1 xous	weller	JAA.	246 N	V Wa	shir	igto	n St 1	Roci	kvil	le.	MD20	850

Physician /Medical Examiner

> the burial-transit physician as attending use jo detached signed to is certificate has been si director, page 2 should filled in by the funeral After after death.

The law requires that the death certificate be executed

Hospital or Attending

the

2

within 24 hours after To the Funeral Direct

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that initiated events resulting in death) Last Physician/Medical Part II. þ Completed Be 25. Was case referred to medical P Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

Immediate Cause (Final disease or condition resulting in death)

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ue to (or as a consequence of

Due to (or as a consequence of):

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

Day Year

3 Probably 4 Unknown

Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use con	tribute to the cau	se of death?
	1 ☐ Yes	2 🗆 No	3 🗌 Probably	4 Unknov

24a. Wasan autopsy performed? 2 ☐ No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1/4 Yes 2 \( \text{\subset} \) No

1 XYes 2 □ N	0
27. Manner of Death	
1 Natural	5
2 Accident	

3 Suicide

(Check only one)

Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 111664

28b. Time of njury 7 AM 28c. Injury at Work? 1 ☐ Yes 2 🚺 No

Other: 4 Nursing Home 5 Residence 6 ☐Other (Specify) 28d. Describe how injury occurred Moletinen

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Nu City or Town, State) June 1 Smil

29c. License number

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

November 17, 2004

State Registrar

THEODOREM, Fin 31. Date filed (Month, Day, Year) 2004

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

	1	State of Maryland / Department State of Maryland / Certification		•	ene 2001	38910
Physician /Medical		1. Decedent's Name (First, Middle, Last)  Ruth E. Meyerho FF	th. Town and position of Doob	2. Date of Death Month	Day Year	3. Time of Death  11: 45 P M
Examiner Funeral Director		Montgomery Hospice-Casey House Ro	ity, Town, or Location of Death  Ockv111e  der 1 Year   If Under 24 Hrs.   If Under 24 Hr	8. Date of Birth (Month, Day, You March 9,	4c. County of Death  Montgome  9. Birth Co. 1923 New	
with the Maryland or 28a-f ehow	rector	10a. State     10b. County     10c. City, Town or Location       Maryland     Montgomery     Silver Spr	ing Zip Code	10g	. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🕅 No untry?
er death v	by Funerai	1 Never Married 2 Married 1 Y Yes 2 No	20902 cedent of Hispanic Origin? (Spe pecify Cuban, Mexican, Puerto s 22 No Specify:	cify Yes or No- Rican, etc.)	USA  14. Race - Amer Black, White  Specify:	
Maryland 21215-0036 d 2 should be filed within 72 hours att ith and Mental Hygiene. 77 Is marked other then "neture!", or "treumatic event, the Madical Exami TO Re Completed by E	compieted	Elementary/Secondary (0-12) College (1-4or 5+)  12 Homemal	work done during most of worki Tuse retired)	ng 16	b. Kind of Business/I	ndustry
aryland should be file and Mental Hy s marked oth umatic event	e C	17. Father's Name (First, Middle, Last)  William H. Rydberg  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addr	18. Mother's Name  Elvi ess (Street and Number or Rura	ra E. Lu	nd	iip Code)
Baltimore, Ma Demit. Pages 1 and 2 Department of Health a Mportant: If flem 27 is any injury or wher tree		20a. Method of Disposition  1 □ Burial 2X Cremation 3 □ Removal from State	Brook Road, Sou Name of or other place)	ate 200	c. Location - City or 1	Fown, State
Balti permit. Departri Importa any inju		21. Signal re Funeral Service Licensee  22. Name  500 Ut  23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the n	and Address of Facility Fra	ncis J. ( West, S:	Collins Fu ilver Spri	ineral Home ing, MD 2090
executed was and trial-transit  Examiner  Examiner	niner	shock, or heart failure. List only and cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Primary Peritoneal  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Carcinoma			Interval Between Onset and Death Months
376 ate be ate be he bu	ICAI EXA	resulting in death) Last  C.  Due to (or as a consequence of):  d.  IF FEMALE:  23b. Was decedent organit  23c. If yes, outcome of pregnancy	c pregnancy		23d. Date of deliver Month	very Day Year
S, P.O es that the igned by th be detache	ò	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other 9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying		23e. Did tobac	co use contribute to	
	e complete	25. Was case referred to medical		24a. Was an autopsy performed	prior to c d? death?	opsy findings available ompletion of cause of
Sion of tending Physical Cor: After this the funeral discontinuation: To	0	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3  27. Manner of Death	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	ne 5 Aesidenc 28d. Describe how	e 6 V Other (Specinjury occurred	
Hospi 24 hou 5 uner stely fill		4 Homicide  determined  298. Flade of liningly Activities, lace building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurr (Check only one)  2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	red at the time, date and place, a	City or Town, S	State) Se(s) and manner as	stated.
To the within 2 To the complet	W	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29c. License number BR 4216114		Date signed (Month	
State Registrar	_	Chitra Ragagopal, MD 6001 Muncaster Mil 31. Date filed (Month, Day, Year) NOV 2 2 2004 337 Registrar's Signature	11 Road, Rockvi	11e, MD 2	20855	

			For State Registrar	State of N	/larylan	d / Depa <i>Cei</i>	artment tificate	of H	ealth a Death	and Me	ental Hy	giene Reg. No	2004	38911
	Physici	an	1. Decedent's Name (First, Middle, Las	•	a an -Va	20017					2. Date of De	ath	7, 2ď%4	3. Time of Death
	/Medic	al	Equilla Anna Cog	<u> </u>		incey	4b. City, To	own or	Location o		Novemb		County of Deat	8:15 A M
	Examin	er	Montgomery Casey		•	r	Rock			, Death			lontgome	
	Funeral		Social Security Number 6. S	ex 7.7		last birthday)	If Under 1	Year Days	If Under 2	24 Hrs.	8. Date of Bir	th y. Year	9. Birt	hplace (State or Foreign untry)
	Director		577-60-7009 Usual Residence of Decedent	UM ZAUF	89	Yrs.					Sept.	19,	1915 Wa	sh. D.C.
	wor #		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	e Mar	ctor	Maryland Montgome	ery	Si	lver S	ring							XXYes 2 ☐ No
	vith th	Director	10e. Street and Number 1703 Staley Mane	r Drive			10f. Zip C	ode 904				-	tizen of What Co	
	ns 23g	Funeral	17 05 Scarey Ham	12. Was Deceder	nt Ever in U.	S. 13. V			spanic Orio	rin? (Spec	ify Yes or No		ted Sta	
920	be filed within 72 hours after death with the Maryland nat Hyglene. Id other than "netural", or items 23a or 28a-f show svent, the McGral Examiner must be notified at	ğ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2\( \) If Yes, Give Year or Dates	s? <b>X</b> No	1:	Yes, specify			, Puerto R	ify Yes or No ican, etc.)	,-	Black, White	
2-0	72 hoi	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	lent's Usual (	Occupa:	tion	of working	7	16b. K	(ind of Business/	Industry
121	within ene. than "	mple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	ļ.	kind of work OO NOT use					TT	C C	
9	e filed within al Hygiene. cother than vent, the Mark		12 17. Father's Name (First, Middle, Last)			Adı	Lnistr				First, Middle,		S. Gove:	rnment
Maryland 21215-0036	2 should be and Mental Is marked c	To Be	Virgil G. Cogdel	.1							Cook		,	
lary	2 sho and h ls ma		19a. Informant's Name/Relationship										or Town, State, Z	lip Code)
e, <b>Z</b>	1 and 1 and 1 and 27 1 ther tr		James V. Mason /	Son	20h P	9108 lace of Dispos			d Ct.	, Lar	nham, 1		20706 ocation - City or	F C1
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any Injury or other traumatic state.		1 🖾 Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify		e c	emetery, cren ryland	natory or other	er place		1/23/			rel, Mai	
altir	partme partme porter / Injur		21. Signature of Funeral Service Licen		1141								al Servi	
m —			Undre' The	mpson									. D.C.	20012
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause one cause on each	ed the death line.	n. Do not ente	er the mode o	of dying	, such as o	cardiac or	respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Q	1 Fail									Onset and Death
	Examiner			b Debi	ıs a consequ 1 -i + sz	uence ot):								
į.	₽ ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		is a consequ	uence of):	<del></del>		<u> </u>					
\	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or a	is a consequ	ionoo of):	-							
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical E		d	.0 4 90/10040	201100 017.								
9	tificate ng phy as the	ledic		u										
Вох	leath certific attending p	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Fetal	death 3	Ectopic preg						23d. Date of deli	very Day Year
<u>o</u> .	that the de ed by the a detached f	Physician/Me	1 ☐ Yes 2 ☐No 9 ☐ Unknown	4□Pregnant 9□ Unknown	at time of de	eath 5□	Other (speci	ify)					WOTE	Day
α.	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions co	ontributing to death	but not resu	ılting in the un	derlying caus	se giver	n in Part I.		23e. Did to	obacco (	use contribute to	the cause of death?
ord	w require been sig should b	ted t									101	es 2	<b>K</b> No 3□ Pro	bably 4 Unknown
Vital Records,	as b	Completed									24a. Was autop	sy	prior to o	opsy findings available ompletion of cause of
alF	ate pag	e Cor	05 Man								1 Yes	rmed? No	death? 1 ☐ Yes	2□ No
Ž	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	Hospital:	tient 2 🗆	ER/Outpatient	3□ DOA	Other			Check only o		€ <b>V</b> i∩thor (Coos	Whospice
n of	ng Phys ter this neral di		27. Manner of Death  1 XNatural 5 Pending	28a. Date of In (Month, D		28b. Time of		Injury a Work?			d. Describe h			mynospice
Siol	tendir leath. tor: Ai	catle	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	es 2 N					
Division of	lor At after o Direct In by	Certification:	4 Homicide determined	286. Place of I	njury - At hor etc. <i>(Specify</i>	me, farm, stre	et, factory, o	ffice		28	f. Location (S City or Tow			al Route Number,
	To the Hospitel or Attending Physwithin 24 hours after death.  To the Funerel Director: After this, completely filled in by the funeral dir	edical C	29a. Certifier (Check only one)  1   Certifying Physical Example (Check only one)	mer: On the basis	or examinat	wledge, death ion and/or inv	occurred at t estigation, in	he time	a, date and nion, death	l place, an	d due to the d	cause(s)	and manner as	stated. to the cause(s)
	ro the within :	Mec	29b. Signature and title of certifier	and manner s	natou.		29c. L	icense	number			29d. Dat	te signed (Month,	Day, Year)
)			· KW		~	77	D3	3563	5			Nove	ember 17	, 2004
	20		30. Name and address of person who o											-
		to	Joseph Kaplan, M		l Munc trar's Signat	aster				ckvi1	le, MD	20	0851	
	Sta Registr		NOV 2 2 20		war.	5	Spon	Ks/	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** John Wilson Nichols 2004 4:00 P.M 11 -14-/Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WICOMICO 9036 Williams Mill Pond Road Delmar If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 8-7-1951 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1⊠M 2□F Hours 219-60-2262 Pa. Director 53 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heelth and Mentai Hygiene. 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinst must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Wicomico Delmar Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9036 Williams Mill Pond Road 21875 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Upholsterer Yacht Builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norma Maddox Nichols Ernest Nichols

20b. Place of Disposition (Name of

**Physician** /Medica

Examine

19a. Informant's Name/Relationship (Type, Print)

Patricia Nichols, Wife

20a. Method of Disposition

attending physicien and for use as the burial-transit been signed by the should be detached

The law requires that the death certificate be executed

To the Hospitel or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

	1 X Burial 2 ☐ Cremation 3 ☐ Remo  '4 ☐ Donation 5 ☐ Other (Specify)		t. Stephens		11-18-04	Delmar, De	•		
	21. Signature of Funeral Service Licensee	,	22. Name Shoi	and Address of Fact Funeral					
Examiner	23a. Part1. Enter the disease, of complication shock, or head failure. List only one call immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ns that caused the duse on each line.  Due to (or as a cons	eath. Do not enter the n				Approximate Interval Between Onset and Death		
	in the past 12 months?	yes, outcome of pre	gnancy etal death 3 ⊟Ectopi	c pregnancy (specify)		23d. Date of de Month	blivery Day Year		
Completed by Physician/Medical	9 Unknown  Part II. Other significant conditions contributed to the sign		resulting in the underlyin	ig cause given in Pai	24e. Was a autops perfor	23e. Did tobacco use contribute to the cause  1  Yes 2 No 3 Probably  24e. Was an autopsy performed prior to completion death?  1  Yes 2 No 1 Yes 2 No			
Be (	25. Was case referred to medical examiner?			26. Pla	ce of Death (Check only or	re)			
	1 ☐ Yes 2 ☐ No Hospi	tal: 1 🗌 Inpatient 2	PER/Outpatient 3□	DOA Other: 4	Nursing Home 5 Reside	ence 6 Other (Spe	ecify)		
Certification; To	2 Accident investigation	a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred			
Certific	3 Suicide 6 Could not be determined	te. Place of Injury - A building, etc. (Spe	t home, farm, street, fac ecify)	tory, office	28f. Location (S. City or Town	reet and Number or R n, State)	ural Route Number,		
Medical (	(Check only 2 Medical Exeminer:	n: To the best of my li On the basis of examind manner stated.	knowledge, death occurr ination and/or investigat	ed at the time, date ion, in my opinion, d	and place, and due to the c eath occurred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)		
Ž	29b. Signature and title of certifier	<b>&gt;</b>		29c. License numbe	0614	9d. Date signed (Mon	th, Day, Year)		
	30. Name and address of person who comple	ted cause of death (I	tem 23a) (Type, Print)	or-Lorra v	ne Jarra	h			

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9036 Williams Mill Pond Rd., Delmar, Md. 21875

Date

21801

20c, Location - City or Town, State

DHMH 17 Rev 1/2001

State Registrar 32. Registrat's Signature

Pemberton & S

31. Date filed (Month, Day, Yea

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Coleman Brian Norwood /Medical November 17,2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ⋅ M 2 □ F Months Days Hours Min Director 015-07-7274 Aug. 16,1914 Massachusetts Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or itams 23a or 28a-f shov the Mudical Examitmer must be motified at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 13614 Colefair Drive Funeral 20904 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐Yes 2 f Yes, Give 1 ☐ Never Married 2 ☑ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver other Airlines permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injuxer other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) Be William Norwood Annie Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorice Norwood Wife 13614 Colefair Drive Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cometery crematory or other place)
Gate of Heaven
Cemetery 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov. 23, 2004 Silver Spring, Maryland 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. Anne Harrie Wike 500 University Blvd.,W.,Silver Spring,MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner b Sepsis Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter or darrying Cause (Disease or injury Examiner sician and burial-transit The law requires that the death certificate be executed c Advanced Parkinson's Disease that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Day Month Year 4 Pregnant at time of death 5 Cther (specify) P.O. 9 Unknown 9 Unknown á signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide in by 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dato and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the nd title of certifier 29b. Signature i 29c. License number 29d. Date signed (Month, Day, Year) SHAMIM D 54284 3 November 18,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahid Shamim, M.D. 1299 Lamberton Drive Silver Spring, Maryland 20902-3411 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 22 2004 Registrar

			For State AMENINE	State of Marylan		artment of F		-	giene	38911
	Physicia	an l	1. Decedent's Name (First, Middle, Last,	)		timodic or	Douin	2. Date of De Month	ath Day Year	3. Time of Death
	/Medic		Thomas Franklin			4b. City, Town, o	al antiba d' Di		er 17, 2004 4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give Rexford Place	street and number)		Greenb		atn	Prince G	
	Funeral		5. Social Security Number 6. Sec		last birthday)	If Under 1 Year	If Under 24 H	s. 8. Date of Bir	th 9. Bi	rthplace (State or Foreign
Ш	Director		578-16-3721	<sup>2M 2□ F</sup> 87	Yrs.	Months Days	Hours Mi	Dec	1916 Wa	shington, DC
	pu k		Usual Residence of Decedent  10a, State 10b, County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	daryla f sho	ō	Maryland Prince (		linton					1 No Yes 2 No
	28a-	Director	10e. Street and Number	eorges c.	LIIICOII	10f. Zip Code			10g. Citizen of What C	ountry?
	h with	al D	9400 Pella Place	<u> </u>		2073	5		United St	ates
	ams 3	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - Am Black, Whi	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show tha Madical Exartimer institut in	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify:	
0 0	tural	ed b	15. Decedent's Edu		16a. Dece	dent's Usual Occup	pation		AITICAN 16b. Kind of Business	American  s/Industry
212	hin 72 In "ne Medik	plet	(Specify only highest grad	le completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of w d)	rorking		
21	ad wit	Completed		2	Mini	ster			Church	
Maryland 21215-0036	be filk	Be	17. Father's Name (First, Middle, Last)  Robert F. Odellas	~					, Maiden Sumame)	
7 2	d Mer narke	To	19a. Informant's Name/Relationship (T)		19h Maili	na Address (Street		Berry	er, City or Town, State,	Zin Code)
Z	th an		Virginia 0. Brocki						-	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avant, the Medical Exprintmential to multiply at once.		20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of matory or other place		Date	20c. Location - City of	
E	Page int: #		1 ☐Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	demoval from State		ln Cemet	.	26-2004	Brentwood,	MD
Baltimore,	rmit. spartn sports y inju		21. Signature of Funeral Service Licens		22	2. Name and Addre	ss of Facility M	cGuire Fu	neral Serv	ice
	80789		Lowand	1. Cegum			<del></del>		Wash. D.C.	20012
P			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	tn. Do not en	er the mode or dylr	ng, such as card	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Aspiratio  Due to (or as a consec		monia				1 week
Р	Examiner			Alzheimer	_	ease				
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec						
	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
8760,	cate be executed physician and the burial-transit		roduling in dealiny East	Due to (or as a consec	quence or):					
687	death certificate be executed e attending physician and of for use as the burial-transit	edical	•	d						
Box (	death certifica attending phase as to	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		7			23d. Date of de	alivery
	ie death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown		∃Ectopic pregnance ∃ Other (specify) _	y 		Month	Day Year
P.0	that the d ed by the detached	Physician/Me	9 Unknown			a daab is a aa aa aa	an in Dani	220 Did+	tobacco use contribute t	to the source of death?
Ś	Se un e	by	Part II. Dther significant conditions co Hypertension, G1		sulling in the o	moenying cause giv	ren in Fan I.			robably 4 🗀 Unknown
Ö	w require been sig	Completed			Digos			24a. Was	-	utopsy findings available
Rec	e la has	mpl	Chronic Obstruct	ive ruimonary	Disea	se		auto <sub>l</sub>	psy prior to prmed? death?	completion of cause of
tal		ø	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath (Check only o	2 XNo 1 ☐ Ye.	
of Vital Record	S (4) =	To B	examiner? 1 Tes 2 XNo	Hospital: 1 Inpatient 2	] ER/Outpatie	nt 3 DOA Ott			dence 6 X Other (Spe	Assisted ecify)Living
	ding Ph) h. After thii funeral c		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wo		28d. Describe	how injury occurred	
Sio	an or:	catle	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	OOf Leasting (	Chand and Musika and	New / Courts Marshar
Division	o after	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, tarm, st ify)	reet, factory, office		City or To	Street and Number or F wn, State)	tural Houte Number,
J	urs urs ille			vsician: To the best of my kn						
	To the Hosp within 24 ho To the Fune completely f	edical		iner: On the basis of examination and manner stated.						
	To the To the To the Comp	M	29b. Signature and title of tertilier	)		29c. Licens			29d. Date signed (Mon	
)	5		· Lill	M.D.		D555	)) 		November 1	9, 2004
			30. Name and address of person who c	7505			m Desire	Cmaanl	5.14 MD 2	0770
	Sta	ite	Thomas E. Masle 31. Date filed (Month, Day, Year)	32. Registrar's Sign		1		, Greenl	bert, MD Z	0770
	Regist		31. Date filed (Month, Day, Year) NOV 22 206		B	sparks	and the same of th			

		1	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H			ne 2004	38915
			1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	DayYear	3. Time of Death
	Physicia /Medic	al -	THOMAS 4	Peed Sr.				November	16, 2004	2:20 <sup>a</sup> <sup>M</sup>
7	Examin	er	4a. Facility Name (If not institution				Location of Death		4c. County of Death	
	<b>-</b>		Charlotte Hall V 5. Social Security Number		e (In yrs. last birthday	Charlot If Under 1 Year	te Hall If Under 24 Hrs.	8. Date of Birth	St. Mary	Splace (State or Foreign
	Funeral Director		577-42-4000	1 <b>⊠</b> M 2□F	<b>71</b> Yrs.	Months Days	Hours Min.	March 17	, 1933 Was	place (State or Foreign http:) nington D.C.
	pu »	⊢	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Manyle f sho		MD Calv	ært	Dunkirk					1 ☐ Yes 2 XNo
	r 28a-	Funeral Director	10e. Street and Number	010		10f. Zip Code		100	. Citizen of What Cou	ntry?
	th with	aiD	2614 Apple Way			20754			U.S.A.	
	er dea	nuel	11. Marital Status	12. Was Decedent Armed Forces? ied 1 ☑ Yes 2 □	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	Ir, or i	by F	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1954	1 ☐ Yes 2 🔀 No	Specify:		Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show the Madical Exeminer must be notified at	Completed	15. Decedent	's Education	(Giv	edent's Usual Occup	during most of work	ing 16	b. Kind of Business/Ir	ndustry
2	d within 72 ho giene. Ir than "natu	mple	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	)		Communicat	ions
2	be filed with stal Hygiene od other than event, I''s a		12 17. Father's Name (First, Middle,	Last)	Filst	ilee1	18. Mother's Name	e (First, Middle, Ma		10110
an	ed tal	To Be	Hamoton Peed				Sophie	Willia	ns	
Maryland		lan-	19a. Informant's Name/Relations	nip (Type, Print)		_	and Number or Run	al Route Number, (	City or Town, State, Zi	p Code)
	Health a Health a tem 27 is		Shirley Peed (	(wife)		4 Apple W			<b>754</b> Oc. Location - City or T	own State
Baltimore,	Pages 1 ar ment of Hea ant: if item ary or othe	П	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		f i	osition (Name of ematory or other place				
ΕË	그는만큼 .	1	<ul><li>4 □ Donation 5 □ Other (S</li><li>21. Signature of Funeral Service.</li></ul>		Maryland	Vet. Cem 22. Name and Addre	etery 11- ss of Facility T. 20	-19-2004 Funonal	Cheltenha Home Calv	m, MU
Ва	Depariment Department		V 1	Pared / Chic	2/ 8	125 South	ern Marvl	and Blvd	Owings,	MD 20736
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each i	d the death. Do not elline.	nter the mode of dyin	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Fnysician		Immediate Cause (Final disease or condition	a. Ası	piration	Pneu	monia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	oiration s a consequence of): kinSons	Dis	PALO			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	E a consedences of).	> 10	cuse			
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	$_{\circ}$ $\mathcal{D}\epsilon$	ementi	`a_				
,092	requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the buriat-transit	i Ex	resulting in death) Last	Due to (or as	s a consequence of):					
6876	physic the b	dicai		d						
Box 6	death certifica attending ph d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐Ectopic pregnancy	,		23d. Date of deliv	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)			Month	Day Year
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ds,	signed d be del	d by	Hupothy	midis	m			1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
Records,		Completed						24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Re	9 C 9	dwo						autopsy perform	ad?   death?	2 No
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of V	Phyaician: this certific ral director,	2	1 ☐ Yes 2. No	Hospital: 1 ☐ Inpat 28a. Date of Inj			4 A radiality in	ome 5 Resider	ce 6 Other (Spec	ify)
ou c	ftel ne	tion:	27. Manner of Death  1 Natural 5 Pending investi	/Month ()	ay Year) Zob. Tille	Wo	rk? Yes 2 □ No	200. 00001100 1101	injury document	
Division	Attending r death.	flca	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Ir	njury - At home, farm,	street, factory, office	_	28f. Location (Str. City or Town,	eet and Number or Ru. State)	ral Route Number,
Ö	s effe s Dire	Certification;	4   Homiciae	Building, 6	etc. (Specify)			ony or room,		
	To the Hospital or Attendii within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	Medicai	(Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	of examination and/or	ath occurred at the ti investigation, in my o	me, date and place, ppinion, death occur	, and due to the car rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	o the ithin 2 o the	Med	one) 29b. Signature and title of certifie	and manner s	stated.	29c. Licens	se number	29	d. Date signed (Month	. Day, Year)
	F ≯ F 8		· Paro	Same	1110	D	45092	2 1	lovembe	r 16 2004
	= , 1		30. Name and address of person	who completed cause of	death (Item 23a) (Typ	e, Print) Pa	rul Ja	ni I	LAD Oak	r 16,2004
	2+1		31. Date filed (Month, Day, Year	Kodd Su	te #205	5 triv	ice trea	erick,	MU 206	218
	St Regist	ate trar	51. Date med (worth, Day, Feat	2. nagis	H. Carle	D				
			MIIV 7 9 /111/	CHARLES !						

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** bora 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Hospice The Lake Coastal Wicomico If Under 1 Year / If Under 24 Hrs. . Sex 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min Year 1 ☐ M 2 💢 F Yrs Director 231-32-8919 74 12,1930 FLORIDA TAMPA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f ehow item 27 is marked other than "natural", or iteme 23a or 28e-f show other traumatic event, it is Medical Exercition or mail be notified at 1X Yes 2 □ No Director MD WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 405 PENNSYLVANIA AVENUE Completed by Funeral 21801 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "netural; or ites any injury or other traumatic event. It a Medical Exerciti 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3X Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 11 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GARLAND LESTER SPENCER NELL WORRELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V. CAROL WALLINGFORD - DAUGHTER 405 PENNSYLVANIA AVENUE, SALISBURY, MARYLAND 21801 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State PARSONS CEMETERY \* 4 ☐ Donation 5 ☐ Other (Specify) 11-17-2004 SALISBURY, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 lley 23a. Part I. Enter the disease, or comprications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Pevelorb VASLEMA **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE 950 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 Z No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an After this certificate has page 2 1 Yes or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 1 Yes Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 Tyes 2 No 2 Accident investigation the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

RUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004 7

Conal

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32. Registrar's Signature

29c. License number

			1 - For State Registrar	e of Maryland /		rtment tificate			and M	-	giene Rag. No2	004	38917
	Physici	an	Decedent's Name (First, Middle, Last)	0 0001	1/					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give street and	Lopchoc	K	4h Cih/ T	Town or	Location o	of Dogsth	11	17	2004 County of Death	2105 PM
	Examin	ier	University of Maryla	1 1 1 1	Center	134	11	none	n Dealli			V ( 4	
ĺ.	Funeral Director		5. Social Security Number 6. Sex 1 1 1 M M 2 □	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da SEPT 2	th y, Year)	9. Birth	nplace (State or Foreign untry) RYLAND
	and w.		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	cation							10d. Inside City Limits
	Marylan	tor	MD TALBOT	5	ST. M	ICHAE	LS						1X Yes 2 No
	or 28e	Director	10e. Street and Number			10f. Zip (	Code				10g. Citize	on of What Cou	ıntry?
	23e (151)	ral	106 E. MAPLE AVE.				216					USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f ehow apprintly or other treumetic event, the Modical Eria ill at mast ke indiffied at once.	by Funeral	Arme 1 ☐ Never Married 2 ☑ Married 1 ☐ Y	Decedent Ever in U.S. d Forces? 'es 2 X No s, Give or Dates:		Vas Decede Yes, speci Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		Black, White	
5-0	72 hc	eted	15. Decedent's Education (Specify only highest grade comple		(Give I	ent's Usual	done di	urina most	of working	ng	16b. Kind	of Business/l	ndustry
121	within ene. then "	Completed	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)		OO NOT use ANICA			E D		T A NTD	SURVEY	TNC
	filed withi Hygiene. other then ent, the M	0	17. Father's Name (First, Middle, Last)	U	месп	ANTUA				(First, Middle,			ING
Maryland	should be Ind Mental I	To B	MICHAEL S. ROPCHOCK,	SR.				ВО	NNIE	PHYLLI	S RIC	HARDSO	N
lary	and N is ma		19a. Informant's Name/Relationship (Type, Print)	1	19b. Mailin	g Address (	(Street a	nd Numbe	r or Aura	l Route Numbe	er, City or 1	Town, State, Zi	ip Code)
	1 and 2 Health tem 27		CAROL A. ROPCHOCK/WII					AVE.				MD 216	
Baltimore,	Pages 1 nent of F int; If ite iry or ot		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal f	rom State ceme	etery, crem	sition (Name	her place	1		ate		ation - City or T	
Iŧi	permit. Pag Department Importent; I eny injury o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		- T:	MEMO Name and				-24-200	4 EAS	STON, M.	ARYLAND
Ba	permit. Departr Importe eny inje		Loseph M. Ostrowsl		FE 20	LLOWS 0 S.	, HE HARE	LFENI LISON	BEIN ST 1	EASTON,	MD 2		HOME PA
	Pnysician /Medical		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	hat caused the death. Doneach line.	o not ente	r the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner			Kespin	ton	fa.	(m						
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a o disequenc	ce of):	11		4		A u	. 6		
	certificate be executed iding physician and ise as the burial-transit	xan	that initiated events c.	a to () as a consequence	1) CC ce of):	11 0	Gra	./how	( 6)	of a	ecr		
8760,	ate be e hysiciar he buri	cal	d										
9	rtificat ng phy as th		IE EENALE.										
.O. Box	death e atter d for u	Physician/Med	in the past 12 months?	, outcome of pregnancy ive birth 2 □ Fetal dea regnant at time of death Inknown	ath 3	Ectopic pre Other (s <i>pe</i>					23	d. Date of deliv Month	rery Day Year
Records, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing	to death but not resulting	g in the un	derlying ca	use give	n in Part I.			obacco use Yes 2 🗆	1/	the cause of death? bably 4 □Unknown
3ecc		Completed								24a. Was autop	an osy rmed?/	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
Vital	ysicien: The is certificate hadirector, page	e Co	25. Was case referred to medical					00 81	- ( D 1)	1 Yes	2[No	1 🗆 Yes	2XNo
Ž	Physicien: this certific ral director,	0 8	examiner?  1 Yes 2 No Hospital:	1XInpatient 2□ER/	Outpatient	3 DOA	Cthe	~		(Check only o		☐Other (Speci	fv)
ion of	fing Ph I. After th funeral	Certification: T	1 Natural 5 Pending ( 2 Accident investigation		b. Time of Injury		c. Injury Work		2	8d. Describe I			97
Division	of or Atterder de Directed in by the	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. F	Place of Injury - At home, uilding, etc. (Specify)	, farm, stre	et, factory,	office		2	8f. Location (5 City or Tox		Number or Run	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) (Check only one) (Check only one)	o the best of my knowled he basis of examination manner stated.	dge, death and/or inv	occurred a estigation, i	t the time	e, date and inion, deatl	d place, a	nd due to the d at the time,	cause(s) ar date and pl	nd manner as s lace, and due t	stated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	10		29c.	License	number			29d. Date	signed (Month,	Day, Year)
			11 ex		my	2 i	719	155	d		ul	17/04	
			30. Name and address of person who completed	cause of death (Item 23:	/ /	Print)							
	Sta	ate		2. Registrar's Signature		rong	, M	<b>フ</b>					
	Registi			whi to	Grand								

			1 - For State Registrar		Marylar			t of H	ealth a			Reg. No	7 N N	4	389	18
	* Physici	an	1. Decedent's Name (First, Middle, L Catherine	•	1	D.	1-				2. Date of Dea		, Y	ear	3. Time of De 2:45 P	
	/Medic	al	4a. Facility Name (If not institution, g	Pea		- K	osch	Tour	Location o	4 Dansk	11/23/		County of	Death	2:43 F	M
	Examin	ęr	4605 Danville Ro		91)		, ,	ndyw:		or Death			ince		rge's	
	Funeral Director		577-09-7919	Sex 7 1 □ M <b>*27.3</b> F	Age (In yrs. 89	last birthday) Yrs.	If Under Months		If Under a	24 Hrs. Min.	8. Date of Birth	l	9	. Birthpl	ace (State or Fi	oreign
	land land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10	Od. Inside City L	Limits
	Mary -f sh	tor	Maryland Prince	George's		Brandyv	vine								1 ☐ Yes 2X	<b>I</b> No
	th with the 23s or 28e	Funeral Director	10e. Street and Number 4605 Danville Ro	ad			10f. Zîp		20613			_	izen of Wha	at Count	try?	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If item 27 is marked other then "natural', or items 23e or 28e-f show minportent; If item 27 is marked other the "natural be notified at once."	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Force 1 Yes 2 If Yes, Give Year or Dat	es? ∰No		Was Deced If Yes, spec 1 ☐ Yes		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White, e		
21215-0036	within 72 hor ene. then "natura he Mcdical E	Completed	15. Decedent's (Specify only highest g	Education rade completed)  College (1-4	lor 5+)	1	kind of wor DO NOT us	rk done d se retired	ation furing most )	t of worki	ng		ind of Busir		•	
	d be filed wi ental Hygien cad other th c event, the	Be	9 17. Father's Name (First, Middle, La: Sidney Warre	n Day		ріет	iciar	1	18. Mothe	r's Name Ruby	(First, Middle, Pearl		hool Sumame) Y		tem	
Maryland	nd 2 should be filth and Mental I	ပ္	19a. Informant's Name/Relationship Herbert A. Rosch				_				III, Md			ate, Zip	Code)	
	s 1 an I Heal Item 2 other		20a. Method of Disposition	,01.75011	20b. I	Place of Dispo	sition (Nan	ne of		40.00	ate		cation - Ci	y or To	wn, State	
E C	Pages ient of int: if i		1XPBurial 2 □ Cremation 3  14 □ Donation 5 □ Other (Spec			cemetery, crer dar Hil				1/27	/04	Sui	tland	, Ma	aryland	
Baltimore,	permit. Departmitmporte any inju		21. Signature 1 Funeral Service Lis	-							Kalas F					745
8760,	Physician pe executed (quid bhysician and fund bhysician lise as the prival-transit	Ical Examiner	23. Part. Enter the disease or co sh. k, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ATREM  Due to (o		quence of):	Cand				islase				Approximate Interval Betwer Onset and Dea	ath
O. Box 6	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ★★No 9 □ Unknown		h 2 ☐ Feta nt at time of d	aldeath 3 [	Ectopic pr						23d. Date of Month		y Day Yea	ır
rds, P	es tha gned be de	by	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	nderlying c	ause give	en in Part I.						e cause of deal	
Il Records,	The faw a ate has be page 2 sh	Completed									24a. Was autop perfor	sy med?	prio dea	r to con th?	esy findings ava apletion of caus	ilable se of
Vital	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o					
of		tlon; To	1 ☐ Yes 2 ② No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of (Month,		28b. Time o Injury	_	8c. Injun Work	7 4 □ Nu 7 at 6? Yes 2 □ 1		me 5X Resid 28d. Describe h			(Specify	)	
Division	Prospitel or Attending 24 hours after death. Prunerel Diractor: Afte etely filled in by the fune	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place o	f Injury - At h J, etc. <i>(Speci</i>	nome, farm, str ify)					28f. Location (S City or Tow	Street an m. State	d Number	or Rural	Route Number	۲,
	To the Hospitei within 24 hours of To the Funerel I completely filled	Medical (	29a. Certifier 1 Check only one) 1 Medicel Ex	Physician: To the baseminer: On the baseminer	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date and pinion, deal	d place, a	and due to the ded at the time, d	ause(s)	and mann place, and	er as sta due to	ated. the cause(s)	
	within 2 To the	Ň	29b. Signature and title of certifier				290		number	/			te signed (/			
	86		30. Name and address of person wh	o completed cause	of death (Ite	m 23a) (Type,	Print)		536		C				2016	
4	Sta	te.	Michael Sida Ro 31. Date filed (Month, Day, Year)	o completed cause (A) /M (A) .  32. Reg	// 7? gistrar's Sign	/ //vi/	vysto.	NR	1 4	101-	top Lipty L	15/	on M	0 5	0185	
1	Regist	ar	NOV 2 4 2004	See	K L	200										

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and  1- For State Registrer  Certificate of Death		gient		38919
5	Dharaini		1. Decedent's Name (First, Middle, Last)	2. Oate of De	ath Da	y Year	3. Time of Death
	Physicia /Medic		EARL STANLEY REYNOLDS	12 -		- 2004	09:25 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dec BACTIMURE	ath		. County of Death	0.1.1
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8. Date of Bit	rth	Baltimore 9. Birthp	lace (State or Foreign
	Director		214-50-2859 1X M 2 F 54 Yrs. Months Days Hours Mi	n. (Month, De 8-30-1	1950	Ma	ryland
	pue *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Maryli ed a	tor	Maryland Baltimore Baltimore County				1 ☐ Yes 2 ☐ No
	r 28e	lrec	10e. Street and Number 10f. Zip Code		10g. Ci	tizen of What Cour	ntry?
	th with	Funeral Director	1604 Browns Rd. 21221		l	JSA	
	er dea	uner	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put	(Specify Yes or No erto Rican, etc.)	D-	<ol> <li>Race - Americ Black, White,</li> </ol>	
36	rs afte	by F	1 □ Never Married 2 □ Married 1 ŠYes 2 □ No. If Yes, Give Vietnam 1 □ Yes XX No. Specify: Year or Dates:			Specify: Whi	.te
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene dother than "neturel", or items 23e or 28e-f show event. It a Madical Explainer must be notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	working	16b. K	(ind of Business/In	dustry
218	within 7 ene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			N1 / N	
21	il Hygiene. other than vent, I've Me		12 yrs. N/A Unemployed-Disabled 17. Father's Name (First, Middle, Last) 18. Mother's N	<b>d</b> lame <i>(Fir</i> st, <i>Middl</i> e	Maider	N/A Sumame)	
anc	ould be fi Mental H arked ot atic evel	) Be		y Fish	, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, comano,	
Maryland	should be nd Menta marked umatic ev	ပ္	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or a	<del>'</del>	er, City	or Town, State, Zip	Code)
	ulth a		Deborah A. Reynolds (Sister) 2805 Gray Antler Cou	urt Abing	gdon	, Marylan	d 21009
Baltimore,	of Head	11 3	20a. Method of Disposition  1X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. L	ocation - City or To	own, State
E m	Pag tment tent: I		4 Donation 5 Other (Specify)	-09-04	Ba:	ltimore,	Maryland
Ball	permit. Pages I Department of H Importent: If ite eny injury or ot		21. Signature of Funeral Service Licensee  Como Payame and Address of Facility Lassann Funeral				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card			1. 21236	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence d):				
	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	usit 🗐	nine	Cause (Disease of Mark)				
۷.	exection and in and ial-tra	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and s the burial-transit	ical	d				
39 x	The law requires that the death certificate be executed to the law requires that the attending physician and one is should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
Вох	eath certific attending p I for use as t	cian	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of delive Month	Day Year
Ö.	at the de by the a	hysi	1   Yes 2   No 9   Unknown				
S, D	res thai igned b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		,	use contribute to the	
Records,	w require been sig			_ 15/2	Yes 2	!□No 3□Prob	ably 4 □Unknown
eco	e taw r has be je 2 sh	Completed		24a. Was		24b. Were auto prior to co death?	psy findings available mpletion of cause of
alF				1 ☐ Yes	2 N		2□ No
Vital	sicien: certifica irector,	o Be	examiner?	eath (Check only		6 □Other (Specif	iv)
of	g Phys ter this neral di	I	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe			97
ion	strending F death. ctor: After y the funer	atio	2 Accident investigation M 1 Yes 2 No				
Division	or Attending Physicien: tifer death. Director: After this certific in by the funeral director,	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To		nd Number or Rura e)	al Route Number,
Ω	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifler 1 ★ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to the	cause/s	c) and manner as e	tated
	24 hos 24 hos B Fun etely (	Medical	(Check only one)  2   Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death or and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number			ate signed (Month,	Day, Year)
			Manier M.D. D478	04	12/	01/2004	
	SX		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A MROWIEC 1900 Loch Raven Blvd Beltin		es O	21210	
		ate	24 Date Glad (Afact) Day York 22 Decistoria Signatura	now !	٠ سله ٢١	21218	
	Regist		DEC 0 8 2004 hours 6				
DH	IMH 17 Rev 1/2	2001	DEC 0 8 2004 Server A Aparla				
			ORIGINAL				

			State of Maryland / De	partment of Health and Mental Hyg	iene
				ertificate of Death Re	a. 2004 38920
	Physicia /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Naomi Albaugh Roney	2. Date of Deat November	3. Time of Death 9:30 A м
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Funeval		Frederick Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Frederick  y If Under 1 Year   If Under 24 Hrs.   8. Date of Birth	Frederick  9. Birthplace (State or Foreign
	Funeral Director		219-14-8556	Months Days Hours Min. (Month, Day, Nov. 30	Year) 9. Birthplace (State or Foreign Country) Maryland
	show	_	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	he Ma 28a-f	ecto	Maryland , Frederick Woodsb		1 ☐ Yes 2 X No
	3a or	Funerai Director	11212 Coppermine Road	21798	Og. Citizen of What Country?  U.S.A.
	death	nera		3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Importants if item 27 is marked other than "natural", or Itams 23a or 28a-f show any righty or other traumatic avant, the Predical Energia at Instal Le molling and once.	by Fu	1 Never Married 2 Married 1 Never Married 2 In No	1 ☐ Yes 🏖 No Specify:	Specify:
9	2 hour	ted b	15 Decedent's Education 16a, Dec	cedent's Usual Occupation	White 16b. Kind of Business/Industry
215	thin 7.	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of working b. DO NOT use retired)	
7	iled w dygien thar th nt, the		17, Father's Name (First, Middle, Last)	Secretary  18. Mother's Name (First, Middle, M	Board of Education
and	ld be f ental } kad of ic ava	To Be	William McKinley Albaugh	Mary Six	aldon Gumano)
Maryland 21215-0036	2 should and Men is marka aumatic	<u>,                                    </u>		tilling Address (Street and Number or Rural Route Number,	-
	os 1 and 2 of Health item 27 (			2 Coppermine Road, Woodsbor	
nor	ages int of h			rematory or other place)	20c. Location - City or Town, State
Baltimore,	permit. Pages Department of H Important: If ite any injury or of				
<u>ത</u>	permi Depa Impo any ir once		Solite Salery	22 Name and Address of Facility OBERT E. DAILEY & SON, FUNE 201 NORTH MARKET ST., FREDI	ERICK, MD 21701
Г			23a. Part1. Enter the disease or complications that caused the . Do not e shock, or heart failure. List only one cause of each line.	enter the mode of dying, such as cardiac or respiratory arre	st, Approximate Interval Between Onset and Death
	Pnysician /Medical	9	Immediate Cause (Final disease or condition resulting in death)		24 hrs
	Examiner		Due to (or as a consequence of):  Renal Fall	re	24 hrs
	P ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chuse (Ulsoze or injury)	= 61:	
	ecute and I-trans	Examiner	Consect (Ulspace or Influt) that initiated events resulting in death) Last  Due to (or as a consequence of):	Colitis	10 days
760,	icate be executed physician and s the burial-transit	caiE	Cellulitis:	Facial	14 day 3
89	tificate ng phy as the				7
Вох	ath cer ttendir or use	ian/N		3 □Ectopic pregnancy	23d. Date of delivery  Month Day Year
P.O.	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	1 Yes 2 No 9 Unknown	5 Other (specify)	
	s that med by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	<b>-</b>	acco use contribute to the cause of death?
ord	w require been sig should b	ted t			s 2 12 No 3 Probably 4 Unknown
Vital Records,	The law is ate has be page 2 sh	Completed	Parkinson's Dementi	24a. Was ar autopsy perform	prior to completion of cause of
<u>E</u>			25. Was case referred to medical		Mo 1 ☐ Yes 2 ☐ No
	lysicia lis cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpat	Other	
n of	Attanding Physician: r death. actor: After this certific by the funeral director,		27. Manney of Death 1 Manual 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at 28d. Describe ho Work?	
Division	death ctor: /	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 □ Yes 2 □ No	eet and Number or Rural Route Number,
Ξ	at or A s after il Dira	Certification;	4 Homicide determined building, etc. (Specify)	City or Town	
	To the Hospital or Attandi within 24 hours after death. To tha Funeral Diractor: A completely filled in by the fu	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the ca investigation, in my opinion, death occurred at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		d. Date signed (Month, Day, Year)
•			marchy fring no	D46248	11/19/2004
	5+1		30. Name and address of person who completed cause of death (Item 23a) (Typ Martha Pierce, MD 300 West Ninth St	•	21701
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	reet, Frederick, Maryland	<u> </u>
	Registr	ar	NOV 2 2 2004	& sparks	

DHMH 17 Rev 1/2001

			For	State of		d / Depa	artment of H	ealth and	Mental Hyg	jiene		
			1 - State Registrar			Cei	tificate of L	Jeath		eg. No	JU4	3892
	Physicia /Medic		Decedent's Name (First, Middle CLIFFORD DELE		LDS				2. Date of Dea NOV	Day 20	2 004	3. Time of Death  12:17 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and num	iber)		4b. City, Town, or	Location of Dea	th	4c. Co	unty of Death	
			CIVISTA MEDI				LAPLAT			CH	ARLES	
	Funeral Director		5. Social Security Number 400–36–6140	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, Year)		lace (State or Foreign try) tucky
P			Usual Residence of Decedent  10a, State 10b, County		100 City	, Town or Lo	antina					Od Jacida City Limita
aryla	shoy	-	10a. State 10b. County Maryland Charle	, c		ite P1						0d. Inside City Limits 1 ☐ Yes 2 X No
P, M	Sa-f	ectc	-		4411	100 11				0- 0::	-614/5-1-0	
with	B or	급	10e. Street and Number	a			10f. Zip Code	_		_	of What Coun	uys
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. I Z I 3-UU30 within 72 hours after death with the Maryland	Health and Mental Hygiene.  wen 27 is marked other than "naturel", or Items 23e or 28a-f show ther traumatic event, I've Modical Exp. in er must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed For	ces? 2  No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2∏ No	n, Mexican, Puei Specify:	rto Rican, etc.)		Black, White, ecity: Whi	etc.
P Pon	ature		15. Decedent	's Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/Ind	lustry
<b>6.17</b>	. u	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-	407.51	(Give life.	kind of work done o DO NOT use retired	during most of wo	orking			•
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aryiand should be fit	Aenta rked tic e	TOE	Delbert Reynol	.ds				Bessi	e Reynold	ls		
shor	s ma	-	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Street a	and Number or R	ural Route Number	, City or To	wn, State, Zip	Code)
y <b>Ma</b> and 2 s	Health tem 27 I		Dorothy L. Reyn	olds (wif	e)	4535	Pickeral	l Street	White Pl	ains	MD 20	695
9 -	f item r othe		20a. Method of Disposition 1	3 DRemoval from 9		lace of Dispo emetery, crer	sition (Name of natory or other plac	θ)	Date	20c. Locat	ion - City or To	wn, State
Pag Pag	nent ant: Il		4 □ Donation 5 □ Other (St	pecify)		nity M	Memorial (	Gardens	11-24-04	Wald	Borf, M	D
Dailino permit. Page:	Department of Important: If ite any injury or of once.		21. Signature of Funeral Service I	License	M00173	42	. Name and Addres	es of Facility Eb PIS. La	erwein Fu . White F	meral	Servi MD 206	ces 95
			23a. 711. E ter the disease, or svock, or heart failure. List	omplications that ca	aused the death	. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between
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DOX	attend for us	ian	23b. Was decedent pregnant in the past 12 months?		rth 2 🗍 Fetal	death 3[	Ectopic pregnancy			23d.	Date of delive.  Month	ry Day Year
. કુ <b>ે</b>	the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of de wn	ath 5L	Other (specify)					
That t	ad by detac		Part II. Other significant condition	ns contributing to de	ath but not resu	ulting in the u	ndertvina cause give	en in Part I.	23e. Did tol	bacco use	contribute to th	e cause of death?
COLDS, P.O. DOX 08 wrequires that the death certifical	been signed by the attending physician and should be detached for use as the burial-transit	ted by							1 □ Ye	s 2 N	o 3 🖺 Proba	ably 4 <b>S</b> Unknown
The law r	s certificate has be irector, page 2 sh	Completed					······································	· · · · · · · · · · · · · · · · · · ·	24a. Was a autops perform	ned?	prior to con death?	osy findings available inpletion of cause of
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ysici	is certific director,	To B	examiner? 1 □ Yes 2 🗷 No	Hospital: 1 2	npatient 2 🗆	ER/Outpatier	t 3 DOA Othe	er: 4 🗌 Nursing I	Home 5 ☐ Reside	ence 6 🗀	Other (Specify	•)
VISION OF VITA Attending Physicien:	h. After this funeral di		27. Manner of Death	28a. Date o	of Injury h, Day Year)	28b. Time of	28c. Injury Work	at	28d. Describe ho			
nd in	death. ctor: Afi y the fur	atio	1 Natural 5 Pending 2 Accident investig	gation	n, bay roar,	injury		Yes 2 □ No				
DIVISION of or Attending	within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	and 286. Place	of Injury - At hong, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (St City or Town		umber or Rurai	Route Number,
Hospite	24 hours Funere etely fille	Medical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the ba and mann	isis of examinat	wledge, death ion and/or in	n occurred at the tim vestigation, in my op	ne, date and plac pinion, death occ	e, and due to the caurred at the time, d	ause(s) and ate and pla	d manner as sta ce, and due to	ated. the cause(s)
o the	within Го th	Me	29b. Signature and title of certifier	00	- 12		29c. License	number	2	9d. Date si	gned (Month, L	Day, Year)
_	> 1- 0		> Mules	Vull	ıl		H-00	042445		11_	20-0	14
Sa	1√1		30. Name and address of person PTMENTEL. MT	who completed cause	e of death (Item	23a) (Type,	Print)	FFTCF F	POAD LIAT			2602
J.P	Sta Registr		PIMENTEL, MI  31. Date filed (Month, Day, Year)  NOV 2	2 2004 32. 8	histrar's Signal	turel.	parle	LLTOP W	COAD WAL	אטעי	MD 20	J0UZ
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		For State Registrar	State of Ma	aryland	d / Depa <i>Cer</i>	ırtme <i>tifica</i>	nt of He te of D	ealth and Death	d Men	tal Hygiei Reg.	ne2 0 0 4	38922
Physicia: /Medica		<ol> <li>Decedent's Name (First, Middle, Last Florence Beardsley</li> </ol>		е					N	oate of Death Month Vember	Day 16, 2004	3. Time of Death 6:40 P <sub>M</sub>
Examine	r	4a. Facility Name (If not institution, give Solomons Nursing (		-			y, Town, or I	ocation of De	eath		4c. County of Dea	th
Funeral Director		5. Social Security Number 6. S 577-05-8461 1	ex 7. Age	e (In yrs. la	ast birthday) Yrs.	If Und Months	er 1 Year Days	tf Under 24 H Hours M	Hrs. 8. D	Pate of Birth Month, Day, Ye rch 18,	9. Bir 20. 1916 Ma	thplace (State or Foreign ountry)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner matter is set to item.	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Calvert  10e. Street and Number		10c. City	, Town or Lo		ip Code			10g.	Citizen of What C	10d. tnside City Limits 1 ☐ Yes 2 ☑ No
ns 23a or	Funeral Director	12681 Millcreek Di	12. Was Decedent E	Ever in U.S	5.   13. V		657 edent of His	panic Origin?	? (Specify )		ted Stat	
urs after d	2	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 █️X\ If Yes, Give Year or Dates:		t	f Yes, sp	ecify Cuban	Specify:	uèrto Ricar	n, etc.)	Specify: Wh	te, etc.
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e filed will Hygien other th	Be Con	17. Father's Name (First, Middle, Last)			Legal	Sec		18. Mother's i		La st, Middle, Maid		
should b nd Ments i marked umatic e	o l	Ervin Levi Beards	Type, Print)		19b. Mailin	g Addre	s (Street ar	Adina ng Number or	r Rural Rou	ute Number, Cit	ly or Town, State.	Zip Code)_
E, Mc 1 and 2 Health a tem 27 ls		Kenneth Ratterree	e (Son)		ace of Dispos	sition (N	ame of		ve, L		laryland  Location - City or	
Dartill Dages Department of mportant: If it iny injury or o		1 Burial 2 Acremation 3 \( \) 4 Donation 5 Other (Specify	<i>(</i> )			itán	Crema	atory 1			xandria, l Home,	Virginia
Dermit Depar Impor any in		21. Signature of Funeral Service Licer	I	MOO54	2 Bro	ome	s Isl.	Rd.,	Port	Republ		land 20676
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition	one cause on each lin	the death.		er the m	ode of dying	, such as card	diac or res	piratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence of):							
cate be executed physician and sthe burial-transit	dical Exa	resulting in death) Last	Due to (or as a	a consequ	ence of):							
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25€No	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetat	death 3	Ectopic Other (	pregnancy specify)				23d. Date of de Month	livery Day Year
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with To Con	~	29b. Signature and title of certifier	O Fel	on,	7	2	9c. License	17610	)	290.1	Date signed (Monitory)	17, 2.004
10		30. Name and address of person who	WD -	AIN	ce fo		ericle	_ ~	$\circ$	000	78	
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	1- State of Maryland / Departs  Certif	ment of Health and Me <i>ïcate of Death</i>	ental Hygiene	38923
	Decedent's Name (First, Middle, Last)	2	2. Date of Death Month Day Year	3. Time of Death
Physician /Medical	Carmela Raposo		Month Day Year	1 5.55 PM
Examiner		c. City, Town, or Location of Death	4c. County of Dea	
	, ,	Janham Under 1 Year   If Under 24 Hrs.   a	Prince G	
Funeral Director		onths Days Hours Min.	B. Date of Birth (Month, Day, Year) 9. Bi	rthplace (State or Foreign ountry) t Virginia
2	Usual Residence of Decedent		ar. 203 1755 mes	
anylar show	10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits 11√2 Yes 2 ☐ No
with the Ma t or 28s-f s be notified Director	Maryland Prince George's Bowie			A
a or 3		Of. Zip Code	10g. Citizen of What C	ountry?
eath	12604 Kernwood Lane  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was	20715  Decedent of Hispanic Origin? (Speci	fy Yes or No- 14. Race - Am	erican Indian
of the death value of the second of the seco	Armed Forces? If Ye  1 □ Never Married 2 □ Married I □ Yes 2 □ No  If Yes Give Δ  1 □ If Yes Give Δ  1 □ If Yes Give Δ	Decedent of Hispanic Origin? (Specis, specify Cuban, Mexican, Puerto Ri	can, etc.) Black, Whi	
030 ours a	3 X Widowed 4 □ Divorced If Yes, Give ↑ Year or Dates:	Yes 212 No Specify:	Specify: Wi	nite
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d 21215-0036 d 21215-0036 lifed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23e or 28e-1 show but, the Madical Exertinant be notified at a Completed by Funeral Director	17. Father's Name (First, Middle, Last)	s Payable And Rec	EIVING Accounting First, Middle, Maiden Sumame)	5
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TAPOSO altimore, Mi mit. Pagas 1 and 2 partment of Health a portent: If item 27 is y injury or other tree	20a. Method of Disposition 20b. Place of Disposition	n (Name of Dat		
Page nent cont.	1 \text{\tinit}}}}}}}}} entotines \text{\texin\tinin\text{\text{\text{\text{\text{\text{\t	it in the second	-04 Davidsonvil	le, Maryland
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rds, P quires that an signed I uid be det	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco use contribute to	o the cause of death?
The The sage			autopsy prior to performed? death?	utopsy findings available completion of cause of
/ita	25. Was case referred to medical examiner?	26. Place of Death	117 MILES	
hysic hysical this co	1 ☐ Yes 2 No Hospital: 1 Anpatient 2 ☐ ER/Outpatient 3		5 ☐ Residence 6 ☐ Other (Spe	cify)
ilon conding P ath. or: Attert to tunerate tunerate atton;	2 La Accident	28c. Injury at Work? M 1   Yes 2   No	d. Describe how injury occurred	
Division of tel or Attending F tel or Attending F is after death. el Director: After ed in by the funer. Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, building, etc. (Specify)	factory, office 281	f. Location (Street and Number or Ri City or Town, State)	ural Route Number,
Division of Vital To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, g	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurrence of examination and/or investigated.  Certifying Physician: To the best of my knowledge, death occurrence of examination and/or investigated.	curred at the time, date and place, and gation, in my opinion, death occurred	d due to the cause(s) and manner as at the time, date and place, and due	s stated. a to the cause(s)
To the within To the comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	h, Day, Year)
	1 (808) -	D46075	11/19/04	/
	30. Name and address of person who com reted cause of death (Item 23a) (Type, Prin	) 0	= 1 Car	11
	131 Date filed (Month Day Year) 22 Maintenth Singapure	EL TARKWAY, JOIT	E T CKEENDELL	20710
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print LADMAN MOSTAGHIMU-0.7305 HANDO 31. Date filed (Month, Day, Year)  NOV 19 2004	L)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 25,27,28,a-f, per MF, C841,03/08/05dhb

For State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND#24a+30, perMD11/22/04, BMW, McCoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Physician 16, Nov. Robert Schoenfeld 1330 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**X** M 2 ☐ F 134.14.0278 92 Director Aug. 27, 1912 Poland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumatic evant, I'v. Medical Exandrar must be rollined at 11 Yes 2 □ No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5619 Huntington Parkway 20814 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Economist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Schoenfeld Klara Frankel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health an Important: If item 27 is any injury or pthan training. Gerda Schoenfeld / Wife 5619 Huntington Pkwy., Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 1 Cremation 3 ☐ Removal from State Nov.18,2004 Alexandria, VA 4 □ Donation 5 □ Other (Specify) Mt. Comfort 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityJoseph Gawler's Sons Inc. 5130 Wisconsin Ave. N.W., Wash., D.C. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxic Brain Injury Physician /Medical Due to (or as a consequence of): Examiner Foreign body inhalation (chicken) 24 hrs. Sequentially list conditions, if any, loading to in redict cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner burial-transit Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Cher (specify) the 9 Unknown chcenfeld, Robest 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 22 N Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 🖁 No Chocked on bolus of food 2 X Accident 11/2004 Unknown 28f. Location (Street and Number or Rural Route Number, 56 19 untington Parkway, 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Home within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Chonmo D0061631 11-16-04. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chen, M.D. 8600 Old Georgetown Road., Bethesda, MD 20814 32. Rugistrar's Signature State

Registrar

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State	of Ma	aryland /		rtment tificate			nd Me	ental Hyç ا	giene	04	3892	26
	Dhysieir		1. Decedent's Name (First	st, Middle, Las	t)						-		2. Date of Dea Month	ith Day	Year	3. Time of De	ath
	Physicia /Medic		Lisa Ro		Scoon								lovembe	r 19,20	04	6:13A.	М
	Examin	er	4a. Fecility Name (If not i			number)			•		Location of	Death			ty of Death		
			Suburban I  5. Social Security Number			7 Age	e (In yrs. last b	irthday)		thes	sda If Under 2	4 Hrs.	8 Date of Birt		gomer	y place (State or Fo	oreign
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			Usual Residence of Dece	edent													
	arylar show	_		. County			10c. City, To								1	0d. Inside City L 1 XYes 2 [	
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	with t	ā	10e. Street and Number 8201 16th	Street					10f. Zip (						inida		
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0	Hyg other	Be C	17. Father's Name (First,	Middle, Last)								's Name	(First, Middle,				
<u> </u>	uld be Menta Irked Itic ev	To B	Leslie So	coon							Jı	une (	Gordon				
<u> </u>	2 sho and 1 is ma		19a. Informant's Name/F	Relationship (7	ypa, Print)					•			Route Numbe				
2	and lealth m 27 her tr		June Marin		er								rdale,				
Baltimore. Marvland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Evarial set must be collined at once.		20a. Method of Disposition 1 X Burial 2 □ Cre	emation 3 🗆		om State	20b. Place cemet				1			20c. Location			
<u> </u>	it. Pa		' 4 ☐ Donation 5 ☐ 21. Signature of Furral	-0.		1	Gate					ov.26	6,2004 Vol Fun	Silve	r Spr	ing, Md.	
, &	perm Depa Impo		Zi. Signature de de	SAC									VOL Fun .W. Was				
9			23a. Part1. Enter the dis	sease, or comp	lications th	at caused	the death. Do								20007	Approximate Interval Betwee	
,3	Physician		shock, or heart fails Immediate Cause (Final disease or condition	-	0	rehi	1	<b>4</b> 10 10 1	11451	110						Onset and Dea	th
3	/Medical		resulting in death)				a consequence		11.401	177	· ,						
S.	Examiner		Sequentially list conditio	ons.	b			HG									
3)2	be tis	Examiner	Sequentially list condition any, leading to immedicause. Enter Underlying Cause (Disease or injury	late 2	Due	to (or as	a consequenc	e of).									
Lie	xecute and II-tran	xarr	that initiated events resulting in death) Last		c. Due	to (or as	a consequence	e of):				_			-		
Medica (Exami)	cate be executed physician and the burial-transit	dicai E		l	d	,	·	,									
7 7	death certificate be executed e attending physician and of for use as the burial-transit				0.												
9 ×	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent preg	gnant			of pregnancy 2 Fetal dea	th 3.□	Ectopic pre	anancv					ate of delive		
25 E	e deal he att	sicie	in the past 12 mont		4□Pr		time of death		Other (spe						Month	Day Year	r
DA G	requires that the de een signed by the a		9 Munknown Part II. Other significant	t conditions of	ontributing t	o death h	ut not reculting	in the u	Idorhijna ca	ulea anvoi	n in Part I		23a Did to	hacco use co	atributa to t	ne cause of deat	h2
2 2 5	signe d be c	d by	, at it. Other significant		oratio daily t	o dodiii o	at not resulting	, iii tiio ui	identying ca	iuse givei	it iii i ait i.		1 🗆 Y			ably 4 Unkr	
Q/3/ Q/3/ ecords		ete											24a. Was		Were auto	psy findings ava	dable
10 g	9 - 9	Completed											autop	sy med2	prior to co death?	mpletion of caus	
3 1	(D CT	a)	25. Was case referred to	o medical							26. Place	of Death	(Check only o	2X No	1 🗆 Yes	21 No	
22 Z	90	To B	examiner? 1 X Yes 2 ☐ No		Hospital: 1	Inpatie	ent 2 ER/C	Dutpatien	3 DO	Cther			ne 5 ☐ Resid		ther (Specif	v)	
100	ter th		27. Manner of Death 1 □Natural 5 [	Pending	28a. Da	ate of Inju	v Year)	. Time of	28	Bc. Injury Work	at ?	2	8d. Describe h	ow injury occi	urred		
7-	Attending r death. sctor: A'te by the fune	catic	2 Accident	investigation	7.00	, 13	2004 1	1.00	Q.M.	1 🗆 Y	es 2 K		tall				
7 / 2 / 9 / 10 / 10 / 10 / 10 / 10 / 10 / 10		ertification;	4 Homicide	determined	28e. Pi		ury - At home, c. (Specify)			office	1	2	8f. Location (S City or Tow		nber or Rura	Route Number	a. MD
20.	Hospital or 14 hours afte Funeral Div tely filled in	O	29a. Certifier 1	Certifying Ph	vsician: To	<i>J</i> · · · · · · · · · · · · · · · · · · ·	-1100.	CO death	1	t the time	A date and	Diace a	due to the		manner as s	totad	ייינון
2	CA D	edical	(Check only 2000)	Medical Exam	iner: On th	e basis o	examination a	and/or inv	estigation,	in my opi	inion, deat	h occurre	d at the time,	late and place	and due to	the cause(s)	
	within 2 To the	Me	29b. Signature and title	of certifier	- 0	W	. 12.	Ø.	29c.	License	number	_		29d. Date sign	ned (Month,	Day, Year)	
	(3) V		Patrici	d la	mske	- Mr	ay, m	X		DS	7/9/1	5′		Nov	19,2	004	
			30 Name and address of	of person who o	completed of	cause of o	eath (Item 23a	1	The P	ike,	, B-	100,	Rock	ville,	MD	2085	2
	Sta		31. Date filed (Month, Da				ar's Signature	B	Spo								
j.	Registr	ar	NUV	INNC	判集	-		/-	1-1-								

Ĺ	14-/54/			Plea				d / Depa		of H	Assure Allealth and M	lental Hyg	giene	ble.	3002
100	Physicia /Medic		1. Decedent's Nam		Ga	il .		Stewar			Death  Ib. City, Town, or Lo	2. Dete of Dea Month NOVEMBE	Day	Year 2004	3. Time of Death 8: 47p
	Examin		4a Facility Name (I GARRETT C 5. Social Security N	OUNTY	-	ITAL		lest birthday)	If Under 1 Y		OAKLAND  If Under 24 Hrs.	9 Date of Birth	4c. County GARRE	ГТ	ce (State or Foreign
	Funeral Director		577-54-64 Usuel Residence of	434	1.75	M 227F	64	Yrs.	Months D	ays	Hours Min.	Jan. 25	r, Year)	Country D	)
	Marylan a-f ahow	tor	10a. State MD	10b. County	Garr	ett	10c. Cit	y, T <i>o</i> wn or Lo		ak]	land			100	I. Inside City Limits  1 ☐ Yes 2 ☑ No
	th with the 23a or 28 at be not	ai Dire	10e. Street and Nui		ine				10f. Zip Co	de	21550		10g. Citizen of	What Country USA	n
020	within 72 hours efter death with the Maryland ene. than "natural", or flems 23a or 28a-f ahow the Madical Exartiner must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ied 2덫Mar	ried 1	2. Was Decede Armed Force 1 ☐ Yes 21 If Yes, Give Year or Date	s? ☑ No		Was Decedent f Yes, specify 1 ☐ Yes 2 ☑	Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	Bla	ce - American ck, White, etc v: Whit	<b>5.</b>
21215-0020	in 72 ho n "natur devical	pieted		15. Deceder		completed)		(Give	dent's Usual O kind of work d DO NOT use re	lone d	during most of work	ing	16b. Kind of B	usiness/Indu	stry
nd 212	uld be filed with Mental Hygiene. Irked other than stic event, the has	Be Com	Elementary/Second 12 to 17. Father's Name	h	Last)	College (1-4d	or 5+)		House	ewi	Lfe 18. Mother's Name	e (First, Middle,	Maiden Surnan	Home	
rylaı	should bend Menta	은	Robert 19a. Informant's Na	omo/Polation		o Print)	Ba1		an Address (S	treet	Betty and Number or Run		r City or Town	State Zin C	ode)
Ma	1 end 2 sho Health end am 27 ia m	- 1	Wayne St						-		ne, Oakl			Oldio, Lp o	
Baltimore, Maryland	Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										Md . 21!	550	pproximate hterval Between	
Box 68760,	cate be physicia the bur	Physician/Medical Examiner	Sequentially list co if eny, leading to in ceuse. Enter Unde Cause (Disease or that initiated events resulting in death)	nmediate erlying injury s	6. d.		Ì	or as a consec							
P.O. E	es thet the death certifi igned by the attending be detached for use as	hysici	Part II. Other signif	icant conditi	ons cont	ributing to deat	n but not res	ulting in the u	nderlying caus	se giv	en in Part I.	23b. Did to			he cause of death? bly 4 ☐ Unknowr
Records, I	~ A w	Completed by I										24a. Was a		avail	e autopsy findings able prior to bletion of cause ath?
E Re	The ate h	Com										1 by	'es 2∐Nc	1/2	Yes 2□ No
Vital	Physician: The this certificate ral director, per	o Be	25. Was case referexaminer?		-	ospital:	ationt 2	ER/Outpatie	nt 3 DOA	Oth	er: 4 Nursing Ho	h <i>(Check only o</i> lome 5 ☐ Resid		ner (Snecify)	-
Division of	ttending Ph death. stor: After thi y the funeral	Certification: T	27. Manner of Deat  Natural  Accident  Suicide  Under Homicide	h 5 ∐ Pendi	igation not be	28a. Date of I (Month,	njury Day Year) Injury <u>-</u> At h	28b. Time of Injury			v at	28d. Describe h	ow injury occur	red	Route Number,
ā	40spital or A 4 hours after Funeral Directly filled in by	edicai Cer	29a. Certifier (Check only  29a. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.												
	To the Hospital within 24 hours To the Funeral completely filled	Med	29b. Signature and	)		and manner	stated.				e number OCME		29d. Date signe	d (Month, De	ay, Year)
-	4		30. Name and eddr	1.1+	06	npleted cause of	of death (Item			STI	REET, BAL	TIMORE,	MARYLAN	ND 212	01
· ·	Sta Registr	100	31. Date filed (Mon	th Dey Year	2004		istrar's Signa		20/20						

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	_1	State Registrar	State of Ma	aryland /		rtment of H tificate of L		and M		Reg.	$C \cup U \cup L$	38928
siciar edica	n I	1. Decedent's Name (First, Middle, Last)  DANIEL PAUL SI							2. Date of D Month Novemb	oer '	19, 20	
mine		4a. Facility Name (If not institution, give s University of Mary)	and Medi			4b. City, Town, or Baltim	ore				4c. County of N	Death /A
ral tor			14 0 0 0	e (In yrs. last) 52	yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of B (Month, E JULY	lirth 2, Yea 25	1952	Birthplace (State or Foreign Country) MD
		Usual Residence of Decedent           10a. State         10b. County           MD         MONTGOM	ERY	10c. City, To		ation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Disposit	5	10e. Street and Number 13520 W. OLD BA	LTIMORE	1		10f. Zip Code 2084	1			10g.	Citizen of Wh	at Country?
1	by rur	11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent I Armed Forces? 1  Yes 2 Y If Yes, Give Year or Dates:		If	/as Decedent of Hi Yes, specify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	10-	Black,	American Indian, White, etc. WHITE
Once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2		i+)	(Give k life. D	ent's Usual Occupa ind of work done d O NOT use retired, NESS OW	luring most )	t of work	ing		Kind of Busin	ness/Industry
To Bo		17. Father's Name (First, Middle, Last) AUSTIN LEE SIV	ERT						e (First, Middl ANTZE		en Sumame)	
		19a, Informant's Name/Relationship (Type ALEX SIVERT / S	oe, Print) ON		1352							ate, Zip Code) S , MD 20841
once.		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Re  1 □ Donation 5 □ Other (Specify)  21. Signature → unex veryibe license		ceme	tery, crem ERIC	ition (Name of atory or other place K CREMA Name and Addres	т.	11/	22/04			ty or Town, State
an cal ier		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	multipole to (or as	a consequent	e of):	O. BOX						20838 Approximate Interval Between Onset and Death
	al Examin	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last  Due to (or as a consequence of):										
Dhysician/Modic	rysician/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other <i>(specify)</i>					23d. Date of Month	
1	ò	Part II. Other significant conditions conf	ributing to death bu	ut not resulting	g in the un	derlying cause give	n in Part I.					ite Io the cause of death?  Probably 4 Unknown
	разајшол								1 Yes	opsy formed? 2 1	prio dea	re autopsy findings available r to completion of cause of th? Yes 2 \( \) No
	0	25. Was case referred to medical examiner? 14 Yes 2 □ No	ospital: 1 Anpatie	ent 2 ER/	Outpatient	3 DOA Cthe	r		n <i>(Check only</i> me 5 ☐ Res		6 □Other (	(Specify)
9		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	y Year) fo-	D. Time of Injury			1	anly I	how in		hich in
9	Ca	determined	28e. Place of Inju- building, etc	ury - At home, c. (Specify)		et, factory, office			12 City or To	own, Sta	(10) Rout	or Rural Route Number,
Cortification: To B	∟ د	4   nomicide		roude							reduct,	May land
Cortifica	Medical Certificati	29a. Certifier (Check only one)  (Check only one)	icien: To the pest o	of my knowled examination	ige, death	occurred at the timestigation, in my op	e, date and inion, deat	d place, a	and due to the	e cause	(s) and mand	er as stated. I due to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

THEO DONE MILLING

31. Date filed (Month, Day, Year)

NOV 2 2 2004

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of N	Marylan		artment o			nd Me	ental Hy	gienę Reg. No.	2004	38	929		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Cleo C. Sumpter  2. Date of Death  NOV. 2									200 <b>4</b> ar	3. Time	of Death			
)	Examin	er	4a. Facility Name (If not institution, given Citizens Nur 5. Social Security Number 6. S	last birthday)	4b. City, Town, or Location of Death  Frederick  If Under 1 Year   If Under 24 Hrs.   8. Date of 8						County of Death Frederi  9. Birthp						
	Director			□M 2 <b>/</b> □F	97	Yrs.		Days	Hours	Min.	8. Date of Bi Amonth, Da Aug •	16,	1907 ]	ndia	ana		
	e Marylan a-f show	ctor	MD Fred	erick	10c. Cit	y, Town or Lo	dleto	wn							e City Limits		
<u>5</u>	th with the 23a or 28	Funeral Director	10e. Street and Number 4606 Feldspar Rd.					217	69			10g. Citi	Citizen of What Country? USA				
	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than Medical Examinar must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:				Was Deceder f Yes, specify 1 ☐ Yes 2 ∑		anic Origi Mexican, Specity:	in? (Spec Puerto R	cify Yes or No Rican, etc.)		Black, White,	Rece - American Indian, Black, White, etc. ecify: White			
	d within 72 ho piene. Ir than "natur Ir e Medical	Completed	(Specify only highest grade completed) (G				edent's Usual Occupation le kind of work done during most of working DO NOT use retired)  memaker						own home				
	uld be filed Mental Hygi Irked other Itic event, II	To Be C	17. Father's Name (First, Middle, Last William hen		on Mi	chael					(First, Middle adosk		,				
	and 2 sho laith and i 27 is me er treums		19a. Informant's Name/Relationship (Reah Autz (Da										r Town, State, Zip Wn, MD		69		
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other treumatic en		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spacial			Place of Dispo cemetery, crer sthave	natory or other	r place)	em.		26/04		cation - City or To Denix,				
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	loss		1 3	onald	Address Mai	of Figure 1	omps	on Fu Middl	nera eto	al Home wn, MD	217	69		
	Physician /Medical		23 Part1. En er the disease, or com shipt, — heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Supel	sed the deet	h. Do not ent		of dying,	such as ca	ardiac or	respiratory a	rrest,		Approxin	nate		
8760,	Examining page of the partial stransit the purial transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq as a conseq												
.O. Box 6	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1  Yes 22 No 9 Unknown			Ectopic pregnancy Other (specify)						23d. Date of delivery Month Day					
۵	quires that ( n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the discerning gades given in Part I.							1	e to the cause of death?						
l Records,	ysician: The law requir Is certificate has been si director, page 2 should	Completed								<del></del>	24a. Was auto perfo 1 Yes		24b. Were autopsy findings available prior to completion of cause of death?				
Viita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other:			(Check only						
of	Phys this al dir	2	1 Yes 2 No	1 🗆 Inpa		ER/Outpatier			4 Nurs				Other (Specif	1)			
ion	Attending Physician: or death. ector: After this certifica by the funeral director. p	ation	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	28b. Time of Injury	M 200	Work?					y occurred	ured			
Division of	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State)								I Route N	lumber,					
	To the Hospital or within 24 hours after To the Funeret Director completely filled in the formal of	edical	29a. Certifier Certifying Pl (Check only one) Certifying Pl 2 Medical Exer	nysician: To the be miner: On the basis and manner	s of examina	owledge, death	n occurred at vestigation, in	the time, my opin	date and ion, death	place, ai n occurre	nd due to the d at the time,	cause(s) date and	and manner as s place, and due to	ated. the caus	e(s)		
)	To the within 2 To that complet	M	29b. Signature and title of certifier	Karlin	un	1/	) 29c. L	icense n	971	,		29d. Dat	e signed (Month,	Day, Year	7)		
			30. Name and address of person who	completed cause of		n 23a) (Type,	Print) 944	S+.	Fre	ede	rick,	mp	2170				
*	Sta Registi	2.85	31. Date filed (Month, Day, Year)	- 41	strar's Signa		4	lon		1 7			· · · · · · · · · · · · · · · · · · ·				

DHMH 17 Rev 1/2001

			1 - For Stete Registrar	State of M	aryland		rtment of H		ind Mer		200	) 4	38930	)
	Discosia:		1. Decedent's Name (First, Middle, La	st)						Date of Death Month	Day	Year	3. Time of Death	
	Physici /Medio		Bertha	Mabel	St	tokes				lovember	•	2004	2:25 p M	1
	Examir		4a. Facility Name (If not institution, give	re street and number,	)		4b. City, Town, or	r Location of	Death		4c. County	of Death	<del>-</del>	
			191 Llewelyn Lane	>				ingtow	vn			alve		
	Funeral		Social Security Number     6. S	Sex 7. Aq 1 □ M 2 💢 F	ge (In yrs. la:	, ,	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Y	ear)	9. Birthpl Coun	ace (State or Foreign try)	n
	Director		577-26-5268	- X	80	Yrs.			- 00	ct 2, 1	924	Wash	n., D.C.	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10	Od. Inside City Limits	s
	f sho	ō	MD Calve	rt			Hunti	ingtow	m			į	1 ☐ Yes 21☑ No	
	the Marylar 28a-f show	Funeral Director	10e. Street and Number	:I C			10f. Zip Code	LIIG COW.	11	100	. Citizen of W	/hat Coun	trv?	
	with Ba or	ā					20639						,.	
	ns 23	era	191 Llewelyn Lan	12. Was Decedent	Ever in U.S.	. 13. V			in? (Specify	Yes or No-	USA 14. Race	- Americ	an Indian.	_
10	r Iten	F	1 ☐ Never Married 2 ☐ Married	Armed Forces  1 ☐ Yes 2 ☑ If Yes, Give	? No		Vas Decedent of H Yes, specify Cuba	ın, Mexican,	, Puerto Rica	an, etc.)	Black	k, White,	etc.	
036	urs a	þ	3 Widowed 4 □ Divorced	If Yes, Give X Year or Dates:		1	☐ Yes 2XX No	Specify:			Specify.	wh	ite	
5-0036	i 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show "Iteal Examinational by natified at	Completed	15. Decedent's E			16a. Deced	ent's Usual Occupa	ation	of working	16	b. Kind of Bu	siness/Ind	ustry	П
21	within 7 lene. than "r	ple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use retired	during most (	or working					
2	filed will Hygien ther th	Son	6			bake:	ry worker	<u>-</u>			grocer	y sto	ore	
pd	be file ital Hy od oth event	Be (	17. Father's Name (First, Middle, Last	)				18. Mother	r's Name (Fi	rst, Middle, Ma	iden Sumami	9)		
yla	should be and Mental I marked o	2	Louis	(	Coeyma	n		Ber	tha	I	Mae		Brooks	
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M.		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (Street	and Number	r or Rural Ro	oute Number, C	ity or Town,	State, Zip	Code)	
	of Health of Health litem 27 i			aughter			Ashwood	Drive						
ore	Jes 1 If iter or oth	1	20a. Method of Disposition 1 ⊈Burial 2 ☐ Cremation 3 ☐	Removal from State	l con	ce of Dispo: netery, cren	sition (Name of natory or other plac	(e)	Date	20	c. Location -	City or To	wn, State	
Ĕ	Pages ment of I ant: If its ury or o		`4 Donation 5 ☐ Other (Speci		So.	Memor	rial Gard	lens  11	1-20-2	2004 I	Dunkirl	k, MI	20754	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Ne Iteal Examinating must be notified at any injury or other traumatic.		21. Signature of Funeral Service Lice	nsee			Name and Addres			CALCO COMP	national residence			
ш_	20 E 2 9		Millian (Tro			I	lausch Fu	neral	Home,	P.A.,	Owing:	5, M	20736	
	Physician /Medical Examiner		23a. Par1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acu	d the death. ine.	Cerel	or the mode of dyin	6	Acei	det			Approximate Interval Between Onset and Death	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	ince of):	+1 (	ad	10048	cule	V.Seu.	50		
,	cate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseque	ence of):								-
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9	ing p	0	IF FEMALE:											
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes -2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)				23d. Date Mon	of delive	Day Year	
σ,	res that igned b be deta		Part II. Other significant conditions	contributing to death i	but not result	ing in the ur	derlying cause give	en in Part I.		23e. Did tobac	co use contri	bute to th	e cause of death?	
Records,	uires n sigr	d by								1 🗆 Yes	2 □ No	3 Proba	ably 4 □Unknown	1
00	w require been si should I	Completed								24a. Was an	24b. W	Vere autor	sy findings available	Α
Re	has ge 2	E G		-					_	autopsy performed	1? p	rior to con eath?	pletion of cause of	
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of	Phys r this aral dii	- To	27. Manner of Death	28a. Date of Inj	ury 2	8b. Time of	28c. Injun	4 🗀 IAUIS		Describe how		, , , , , , , ,		
on	ding F th. After funera	tlor	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury		k? Yes 2 ⊟N	40					
Division	Attending r death. sctor: After oy the fune	Certification;	3 ☐ Suicide 6 ☐ Could not t	28e. Place of In	ijury - At hom	e, farm, stre	eet, factory, office		28f.			or or Rural	Route Number,	
D	after Dire	erti	4 Homicide	building, e	tc."(Specify)					City or Town, S	itate)			
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifying Pl	hysicien: To the best miner: On the basis and manners	of examination	ledge, death on and/or inv	occurred at the timestigation, in my of	ne, date and pinion, death	place, and h occurred a	due to the caus it the time, date	e(s) and mar and place, a	nner as sta nd due to	ated. the cause(s)	
	ompl	Me	29b. Signature and title of certifier	1	2		29c. License	e number		29d.	Date signed	(Month, L	Day, Year)	_
	-> F-0		) //.	1011	7		0	331	23		11-1	800	7	
			30. Name and address of person who	completed cause of	death (Item 2	23a) (Type	Print)	7 /				<i>-</i>	<del>/</del>	
	D		Jonathan Lowenth					Ste.	310. 1	Prince 1	reder	ick	MD 20678	3
	Sta		31. Date filed (Month, Day, Year)	32. Regist	ras Signatu	re	hout &	2000	J. V J		- <u> </u>		20070 سيد	_
	Renistr	727	I INIIV 2	2 2004	TALA.	. 16	CLADAN'S B							

State of Maryland / Department of Health and Mental Hygiene 38931 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2004 November 30 1:45 a. M Fae Tabitha Souders /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Beverely Healthcare Center 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Months 1 □ M 2 🖾 F 1928 76 216-74-4880 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f ahow the Medical Examiner must be redified at 1 ☐ Yes 2√☐ No Director Braddock Heights Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4891 White Spruce Lane 21714 USA Itema 23a Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 6 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give AY Year or Dates: 2 3 XWidowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a: Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi and Mental H Be Elsie Manzella Palmer Charles William Metzer, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: It Itam 27 Ia any injury or other trau once. 344 Good Road, Martinsburg, WV 25401 James E. Souders/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 12-1-04 Smithsburg, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fundal Service Agence 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myerville, MD 21773 R 23a. Pent1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cereberal Vascular Accident Physician month /Medical Due to (or as a consequence of): **Examiner** Cellulitis 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of). burial-transit Cardiomyopathy vears Due to (or as a consequence of) physician Box 68760, Physician/Medicai Diabetes Mellitus years attending physi-IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) o the detached 9 Unknown 9 Unknow ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pg Renal Insufficiency, Failure to Thrive, 1 Yes 2 No 3 Probably 4 Unknown Completed been Cardiomegaly, Dysphagia, Blindness, Congestive Heart 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No Failure 1 Yes 2√2 No Division of Vital funeral director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 ⊠Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur, and title of partifier D54749 12/1/2004 Ken 30. Name and address of person who completed cause of death (te / 23a) (Type, Print) 801 Toll House Avenue, D-1, Frederick, MD 21701 Allen Reilly, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	LAGIIIII	CI	1433 SOUTHERN AV			OXON	HILL				PRINCE	GEOF	RGES	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yr □ M 2423 F 55	s. last birthday,	If Under 1 Year Months Days	If Under :	24 Hrs. Min.	8. Date of B	irth	9. B	irthplace Country)	(State or Foreign	
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	r 28a	Director	10e. Street and Number			10f. Zip Code				10g. C	itizen of What (	Country?		
	th with	alD	108 Mohican Driv	е		207	45				USA			
	r dea	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin, Mexican	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - An Black, Wh		dian,	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show the Medical Examinational be motified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐ Yes X Mo If Yes, Give Year or Dates:		1 □ Yes XXXIXIO	Specify:			!	Specifical	ın /	Chinese	
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ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-1 show or other traumatic avant. The Medical Examination until be matified at		20a. Method of Disposition		Place of Disp	osition (Name of matory or other place	(0)		Date	_	ocation - City			
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Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		21. Signature of Funeral Service Licer	9800	2	2. Name and Addre	ss of Facilit	fge	P. Kal	as F	uneral	Home	PA	
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9 x	death certificate be attending physic	/Me	IF FEMALE:	23c. If yes, outcome of prec	nancy						22d Data of d	olivos	**************************************	
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Vital Record	Physician: The law this certificate has tral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth			h (Check only				ATL COUNT	
ō	Phys r this ral di	To	XXYes 2 No 27. Manner of Death	1 ☐ Inpatient 2	□ ER/Outpatie     □ 28b. Time (	nt 3 DOA	4 🗆 Nu	rsing Ho	me 5 ☐ Res 28d. Describe			ecify) E	AT SCENE	
on	Attending in death.	atlon	1 □ Natural 5 □ Pending 2 🗙 Accident investigatio	(Month, Day Year)	Injury	tour Mor	k? Yes 2.DX	No			rowned	in -	tub	
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	To the Hospital or Attending Physwithin 24 hours after death.  To tha Funaral Diractor: After this completely filled in by the funeral di	Med	29b. Signarate and title of certifien	and manner stated.		29c. Licens	e number				ate signed (Mo	nth, Day,	Year)	
•	⊢ 3 ⊢ ŏ		Matille	- talle	l m	2	D.C.M.	.E		1	NOV. 30	0, 20	)04	
			30 Name and address of person who	completed cause of death (II	em 23a) (Туре <b>11</b> 1	, Print) L <b>Penn St</b> i	reet,	Bal	timore,	, Mai	ryland	2120	1	

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
DEC 0.7 2004

			For State Registrar	State	of Marylar		artment of rtificate o		d Mental Hyg	giene 0	04	389	933
	Physicia		1. Decedent's Name (First, Middle ESIELLA	le, Last) MAE	TAYLOR				2. Date of De Month	Day	Year	3. Time of 12:02	Death $\Delta^{M}$
	/Medic Examin	4	4a. Facility Name (If not institution Prince George's F		number)		Cheverly		path	4c. Count	y of Death	e's	
\$ .	Funeral Director		5. Social Security Number  579–30–4823  Usual Residence of Decedent	6. Sex 1 □ M ¾□ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da			1920°	9. Birth Court	place (State of ptry) h Carol	ira ira
	Maryland fied at	tor	10a. State 10b. County		10c. Ci	ty, Town or Lo		Ashington			1	10d. Inside C	ity Limits
	a with the	Funeral Director	10e. Street and Number 302 34th Street,	N.E.			10f. Zip Cod	20019		10g. Citizen of	What Cour	ntry?	
020	iges 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene.  To Health and Mental Hygiene.  To other traumatic event, the Madical Evand set install to ricilities at or other traumatic event.	by Funera	11. Marital Status  1 □ Never Married 2 □ Mar  3 ☒ Widowed 4 □ Divorced	12. Was De Armed	ecedent Ever in U Forces? s 2XXNo Give Dates:		Was Decedent of Yes, specify C		(Specify Yes or No erto Rican, etc.)	Speci	ice - Americack, White,		
213-0030	ithin 72 houne.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade complete		(Give	DO NOT use re	ne during most of v tired)		16b. Kind of I		dustry	
7 0	filed within Hygiene. other then *	Be Cor	11th grade 17. Father's Name (First, Middle,	Last)			raper no		usekeeping Name (First, Middle,		stic me)		
yland	should be ind Mental imarked c	To B		L. Judd					Ida Mae				
Mar	d 2 th a th a trac	8 8	19a. Informant's Name/Relations Mr. Robert M. Tay						Rural Route Number hington, D.0			Code)	
altimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (3		m State	cemetery, crei	osition (Name of matory or other porial Par	place)	Date ember 23, 2	20c. Location	-		nd
Dalt	permit. I Departm Importal any inju		21. Signatore of Funeral Service		losser	22	2. Name and Ad	dress of Facility	Rollins Fu Washingto			2.	
9	Certificate be executed for a continuation of the private and control transit	edical Examiner	23a. Party. Enter the disease, or shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Italy, Learn to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	to (or as a consector (or a consector (or	quence of):	1		the or respiratory as			Approximal Interval Bet Onset and	tween
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	Jing After fune		27. Manner of Death  1 ⊠Natural 5 □ Pendi	28a. Da	te of Injury lonth, Day Year)	28b. Time o Injury	f 28c. I	njury at Work? 1 □ Yes 2 □ No	28d. Describe I			77	
=	i gitt	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined 288. Pie	ace of Injury - At h ilding, etc. <i>(Speci</i>		reet, factory, off	ce	28f. Location (S City or Tox	Street and Num wn, State)	ber or Rura	al Route Nurr	nber,
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		Me	29b. Signature and title of certific		,		29c. Lic	ense number		29d. Date sign	1 .		
>	36		Mudell	6		- 02c\ /*	DC	50532	09	11-1	6-0	04	
	0		30. Name and address of person Werdell Pierson 3					d 20785					
200	Sta Registi		31. Date filed (Month, Day, Year NOV 2 4 2004		Registrar's Sign								

			1 - State Registrar	State of Maryland		irtment of H tificate of L		-	giene 0	04	38934
	Physici /Medic		1. Decedent's Name (First, Middle, Las SEBASTIAN RAFA)	EL TARNAWIECKI				2. Date of Dea Month NOVEMB	Day	Year 004	3. Time of Death 5:35P
	Examin		4a. Facility Name (If not institution, give	ES OF HEALTH		4b. City, Town, or BETHES	SDA	th	4c. County	of Death	RΥ
	Funeral Director		5. Social Security Number 6. Se None Usual Residence of Decedent	7. Age (In yrs. Ia:	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year)	9. Birthp Cour Peru	
	death with the Maryland ims 23a or 28a-f show	tor	10a. State 10b. County Peru		Town or Lo	cation				1	10d. Inside City Limits 1⊠ Yes 2 □ No
	with the a or 28a	Director	10e. Street and Number		Jima	10f. Zip Code			10g. Citizen of N		ntry?
36	should be filed within 72 hours after death with the Marylan of Mental Hygiens within 72 hours after 538 or 288 of show marked other than "naturel", or liems 23a or 288 of show matic event, the Medical Examinar must be in	by Funeral	Las Palomas 202  11. Marital Status  1☆Never Married 2□ Married	12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	l I	34 Vas Decedent of Hir Yes, specify Cubar	n, Mexican, Pue:	rto Rican, etc.)		ck, White,	
215-0036	filed within 72 hours after Hygiene. other than "naturel", or Ite ant, the Medical Examire	Completed b	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grade)  Elementary/Secondary (0-12)	Year or Dates:  Jugation de completed)  College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done d OO NOT use retired,	ation during most of wo	eruvian	16b. Kind of B		Vhite dustry
Maryland 2121	ould be filed wi Mental Hygien arked other th atic event, the	Be	0  17. Father's Name (First, Middle, Last)  Ivan Tarnawiecki		<u>U</u>	nemployed	18. Mother's Na	me (First, Middle,			
Mary	2 2 2 2	2	19a. Informant's Name/Relationship (7			g Address (Street a	and Number or R		er, City or Town,	State, Zip	(Code)
Baltimore, I	0 0		Ivan Tarnawiecki  20a. Method of Disposition  1 ☑ Serial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ce of Dispo netery, cren	alomas 20 sition <i>(Name of</i> natory or other place de la Paz	9)	ma 34, P Date 26-04	eru 20c. Location - Lima Pe	•	own, State
Baltir	permit. Pag Department Important: i any injury o once.		21. Signature of Funeral Service Licens		22 M	Name and Address arshall's 217 9th S	s of Facility Funera	1 Home,	Inc.		20011
8760,	Physician and physician and physician and physician and physician and the physician and physician an	dical Examiner	23a. Park Enter the disease, or compositive compositiv	b	tast ince of): ince of):		,	ac or respiratory ar		3	Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnance 1 Live birth 2 Fetel d 4 Pregnant at time of dea	leath 3 🗆	Ectopic pregnancy Other (specify)				te of delive	ery Day Year
<u> </u>	w requires that been signed by should be deta		Part II. Other significant conditions of	ntributing to death but not result	ing in the ur	iderlying cause give	on in Part I.	23e. Did to		ribute to th	ne cause of death?
Vital Records,	i: The law re icate has bee i, page 2 sho	Completed						24a. Was autop perfor 1 I Yes	med?	prior to cor death?	psy findings available mpletion of cause of No
Division of Vit	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatien 8b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing	Home 5 Resid	lence 6 □Oth		v)
DIVIS	el or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory, office		28f. Location (S City or Tow		er or Rura	I Route Number,
	To the Hospitel or within 24 hours after to the Funerel Dir completely filled in	Medical (	29a. Certifier 1 ☑ Certifying Phy (Check only one)	vsician: To the best of my knowliner: On the basis of examination and manner stated.	edge, death on and/or inv	occurred at the tim restigation, in my op	e, date and plac inion, death occ	e, and due to the durred at the time, d	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
ì	Toth	M	29b. Signature and title of certifier	, M	D	29c. License			29d. Date signed	Month, I	Day, Year)
	De l		30. Name and address of person who can be card Kim				ER DRIV	E, BETHES	SDA, MD	2089.	2
	Sta Registr		NOV 2 4 2004	32. Registrar's Signatu	re						

**			For State Registrar	, ,,,,,,	State of M	aryland / Dep		Health and N		ene.	38935
			1. Decedent's Name	(First, Middle, La	st)				2. Date of Death Month		3. Time of Death
	Physici /Medio		Evelyn		Л.	Taylor					04 15:15 M
1	Examir	er	_		street and number)			or Location of Death	,	4c. County of	
	Funeral		SACRED 5. Social Security No	HEAR 6.S		1 A L ge (In yrs. last birthday		BER LAND		ALLEC	
	Director		210-12-4 Usual Residence of	494 1		79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y May 9, 1	925	Birthplace (State or Foreign Country)
	yland		10a. State	10b. County		10c. City, Town or L					10d. Inside City Limits
	Ba-f s	ctor	MD	Allega	Ту	Cres	aptown				1 ☐ Yes 2 ☐ No
	with th	Funeral Director	10e. Street and Num	h Avenue			10f. Zip Code	21502	10g	. Citizen of Wh	•
	ns 23	eral	11. Marital Status	II Aveilue	12. Was Decedent	Ever in U.S. 13	. Was Decedent of		ecify Yes or No-	US/	American Indian,
36	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or Items 23a or 28a-f show event, the Madical Evantral republic day.	y Fun	1 Never Marrie	_	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give X	No	If Yes, specify Cul  1 ☐ Yes 2 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	Rican, etc.)	Black,	White, etc.
Ö	hours tural',	ed by	3 N Widowed	4 □ Divorced 15. Decedent's Ed	Year or Dates:				1.0		white
215	within 72 ene. than "na	Completed	(Speci	fy only highest gra	de completed)  College (1-4or:	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of work ed)	ring	b. Kind of Busi	ness/industry
21	filed with Hygiene ther than	Сош	1	2	Conage (1-40)	Spinn	ing			elanese	
Maryland 21215-0036	ould be file Mental Hy arked oth	Be	17. Father's Name (	<sup>First, Middle,</sup> Last) Shaffer					e (First, Middle, Ma Shaffer	iden Sumame)	
IZ.	should be and Ments is marked sumatic e	2	19a. Informant's Na		Type, Print)	19b. Mai	ina Address (Stree	t and Number or Rur		City or Town. St	ate Zip Code)
	nd 2 aith a 27 is r trai		Nancy A		daug	hter 754	Fayette S	Street	Cumbe		MD 21502
Baltimore,	0 0				Removal from State	20b. Place of Disp cemetery, cre Restlawn N	osition (Name of ematory or other pla Memorial Ga	ardens		c. Location - Ci _aVale	ty or Town, State
Balti	permit. Page Department Important: Il any injury or once.		21. Signature of Fur				2. Name and Addr Scarpe	ess of Facility Ili Funeral Ho	ome, PA		
			23a. Part1. Exter th	e disease, or com	Dications that caused	d the death. Do not er	108 Vir	ginia Avenue	: Cumberlai	nd, MD 2	1502 Approximate
8760, 3	Physician /Medical Examiner the private and th	Ical Examiner	Immediate Cause (I disease or condition resulting in death)  Sequentially list conit any, leading to improve the cause. Enter Under Cause (Disease or it that initiated events resulting in death) L	ditions, nucleate tying njury	b. Due to (or as	a consequence of):  a consequence of):	BLADI	DER CAI	RUNOM	PA	Onset and Death  / YEAR
P.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	cy		23d. Date of Month	,
	8 20	by	Part II. Other signifi	cent conditions c	ontributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did tobac		ute to the cause of death?
COL	w requires been sites should to	olete							24a. Was an	24b. We	re autopsy findings available
Vital Records,	The ate h	Completed							autopsy performed	d? dea	or to completion of cause of hth? I Yes 2 □ No
Vita	ician: Th certificate ector, paç	Be	25. Was case referre	ed to medical	Hospital:				Check on one		
Division of	Attending Physician: r death. ector: After this certific by the funeral director.	on: To	1 ☐ Yes 2	To 5 ☐ Pending	28a. Date of Inju	ry 28b. Time of		her: 4 Nursing Ho	me 5 Residenc 28d. Describe how		(Specify)
Sio	ittendi death. ctor: A / the fu	icati	2 Accident	investigation 6 Could not be		ury - At home, farm, si		Yes 2□No	20f Leasting (Com-	A == d A (	
Di∧	al or A s after if Direct	Certification;	4  Homicide	determined	building, et	c. (Specify)	теві, тасіоту, опісе		City or Town, S	state)	or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best liner: On the basis of and manner sta	of my knowledge, dea f examination and/or in ated.	th occurred at the tinvestigation, in my	ime, date and place, opinion, death occurr	and due to the caus ed at the time, date	e(s) and manno and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and t	itle of certifier			29c. Licen				Month, Day, Year)
	100		· W	Man		nm	D	25406	D	ECEMB	ER2, 2004
	b			ss of person who d		eath (Item 23a) (Type Memoria	Print) Hespi	tal, Cur	nberlan	nd Ma	ary land 21502
	Sta Registr		31. Date filed (Month	DEC 0'8	32 Registr	ar's Signature	1 Spa	de la			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 12:00 P.M 2004 Taylor November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rose Manor Assisted Living Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔼 F 89 November8, 1915 Maryland Director 220-26-4875 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Experiment be putified at 1X Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 593 Old Stage Road 21703 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Completed by Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fili.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic avant Be Wayman Fincham Bertha Southard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn HarloweDaughter 5420 White Mane Court, Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NOTE: Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Gards | 11/20/2004 Frederick, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 Part Enter the disease, or sall lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so ck, head failure. List only meach line. Approximate Interval Between Interval Between Onset and Death Imme — e Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): **Examiner** rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 🗌 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The design of the best of my knowledge, death occurred at the little, date and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DS8747 11-18-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) 10 Dr. Randall Riesett 10700 Charter Drive, Suite 200, Columbia, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1- State of Marylan		artment of H		-	211111	38937
			Registrar  1. Decedent's Name (First, Middle, Last)	- 001	inicate of t	Jean	2. Date of Death	. No. U U ~	3. Time of Death
	Physici		Shirley Ann Thomas				Month NOVEMBER	Day Year 16 2004	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	MOVEMBER	4c. County of Death	4:04 A <sup>M</sup>
			St. Mary's Hospital		Leonard	town		St. Mary'	s County
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. )		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign
	Director		577-48-8225 68  Usual Residence of Decedent	Yrs.			Aug. 18,	1936 Wash	ington, DC
	land ow			y, Town or Lo	cation				10d. Inside City Limits
	Many t-f sh lifed	tor	MD St. Mary's County Ca	aliforn	าร่อ				1 ☐ Yes 2 X No
	th the	Funeral Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
	23a (23a ust b	al	23870 N. Patuxent Beach Road		20619			U.S.A.	
	or des	unei	11. Marital Status  12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto i	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	I□Yes 2∏ No	Specify:			ite
Ş	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	edt	15. Decedent's Education	16a, Decec	lent's Usual Occupa	ation	16	b. Kind of Business/In	
215	hin 72	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	durina most of workir	ng	-	,
21;	ad wit	Com	11	Wait	ress			Restraunt	
pu	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		iden Sumame)	
<u>∕</u>		2	Clyde Wood			Pearl Pe			
Mai	nd 2 sh alth and 27 is n r traun		19a. Informant's Name/Relationship (Type, Print)  Lois A. Thomas (Daughter)			and Number of Rura. ad, Lusby		ity or Town, State, Zip	Code)
Baltimore, Maryland 21215-0036	1 a Hear Hear Hear Sthe		20a Method of Disposition 20b. Pl	lace of Dispos	sition (Name of			c. Location - City or To	own, State
ğ.	Pages ent of nt: If if		Burial 2 Cremation 3 Hemoval from State		natory or other place		F .	Clinton, M	
===	pernit. Pages Department of Important: If i any njury or once		21. Signature of Fundame Livenson					Home Calve	
ä	F 5 E 6		Michael N Lee					, Owings,	
f			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying	g, such as cardiac or	r respiratory arrest		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	rhyth	mia o	and him	otensive	shock	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequ		ĺ o	2 1.00	An.		C)
	LAGITITICI	-	Sequentially list conditions,	Mas of	tran ar	no rea	ny jan	une	3 0 7)
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	doct	auctive	puln	nonam	disease	10 years
Ć.	be executed sician and burial-transit	Exal	resulting in death) Last  C. Due to (or as a consequ	ience of):	i de live	100			<i>0</i>
760,	The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	cal	d						
89	ntifica ng ph s as th	ed	IF FEMALE:						
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	death 3 [	Ectopic pregnancy			23d. Date of delive	ery Day Year
0	at the dea by the all tached fo	/slci	1   Yes 2   No 9   Unknown 4   Pregnant at time of de	eath 5	Other (specify)			MOITH	Day rear
۵.	that the		Part II. Other significant conditions contributing to death but not resu	ulting in the Our	iderlying cause give	on in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
THOMAS Records,	uires that signed t Id be det	d by	Diabetes mellitus to	900e 11	Anen	€	1 Yes	2 No 3 Prob	ably 4 Unknown
THOMAS	w require been si should b	lete	4 maliosphatemia Pomi	asis	, Sici	le	24a. Was an	24b Were auto	psy findings available
	The la	Completed	Euthoroid Syndrome,	bac	6 pain		autopsy performed	prior to cor death?	npletion of cause of
ANN Vital	(G CT	O	25. Was case refetred to medical	DOCC	u par	26. Place of Death	(Check only one)	No 1 ☐ Yes	214 No
>	ysici nis ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 I	ER/Outpatient	t 3□ DQA Othe	er: 4 ☐ Nursing Hom	ne 5 Residenc	e 6 Other (Specify	1)
RLEY n of	ding Phys h. After this funeral di		27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe how		
SHIRLEY	Attendi death. ctor: A y the fu	catl	2 Accident investigation			/es 2□No			
SEIRI Division	or At after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At homographic building, etc. (Specify	me, farm, stre	eet, factory, office	2	8f. Location (Stree City or Town, S	it and Number or Rura Rate)	l Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	a C	29a. Certifier 12 Certifying Physicien: To the best of my know	wledge, death	occurred at the tim	e, date and place a	nd due to the caus	e(s) and manner as st	ated.
	ne Ho	edical	(Check only 2 Medical Examiner: On the basis of examinat one) and manner stated.	ion and/or inv	estigation, in my op	inion, death occurre	d at the time, date	and place, and due to	the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License			Date signed (Month, I	Day, Year)
			16-20		$\mathcal{D}$	51738		11/16/	2004
	,		30. Name and address of person who completed cause of death (Item						
	(p		KAE AUNG PO BOX 37 HOLLYWOOI  31. Date filed (Month, Day, Year) 32. Registrate Signat	rure	20636				
	Sta Registr		NOV 1 8 2004	1 K	Sparke				
	3			<i>19</i>	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan		· · · · · · · · · · · · · · · · · · ·		

7\	ended #	קר	1 - For State Registrar Dov. P.U. a.c.	State of Maryla		irtment of F			giene 0 (	04	38938
0	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  Cornelia A  4a. Facility Name (If not institution, give s	nn Webb street and number)		4b. City, Town, a	or Location of Death		ath 16 2004 4c. County		3. Time of Death A 18:30 M
	Funeral Director		Prince Georges ( 5. Social Security Number 6. Sex 250-86-0050  Usual Residence of Decedent	7. Age (In y	spital rs. fast birthday) 56 Yrs.	Cheve:	rly If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 1/15/	Princ Princ 1948	9. Birthpla Countr	orges ace (State or Foreign ry) C.
	ne Maryland 8a-f show	Director	MD 10b. County P.G.		City, Town or Lo						ld. Inside City Limits 1
36	be filed within 72 hours effer death with the Maryland stal Hygiene. bd other than "natural", or fleme 23e or 28e-f show event, the Medical Examiner must be notified.	Funerai	1 ☐ Never Married 2 ☐ Marned	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		10f. Zip Code 20785  Vas Decedent of H Yes, specify Cubi	dispanic Origin? (S) an, Mexican, Puerto Specify:		U.S. I  14. Race Blac  Specify	A . e - America k, White, e	in Indian,
Maryland 21215-0036	within 72 hours efter ene. than "natural", or Ite	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	Year or Dates:	16a. Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use retired	pation during most of wor	king	16b. Kind of Bu	siness/Indu	lack
yland 2	should be filed ind Mental Hygis marked other umatic event, II	To Be Co	12 17. Father's Name (First, Middle, Last)	Luellen W	Villiams	cher		Young		θ)	
	is 1 and 2 sho of Health and item 27 Is m other traum		19a. Informant's Name/Relationship (Type Isaiah Webb/hus 20a. Method of Disposition	band		Swan T	and Number or Ru 'err. La			785	
Baltimore,	it. Pages rtment of rtant: If it njury or o		1 Matrial 2 □ Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	lemoval from State	cemetery, cren Sincoln	Memori	al   11/ ss of Facility HO	20/04	Suitlar	nd,ME	
B	permi Depa Impo eny ii		23a. Par 1. Enter the disease, or complications, or heart failure. List only on	ications that caused the de	] 3	910 Sil	ver Hil	1 RD.St	uitland	l,MD.	, 20746 Approximate Interval Between
8760,	death certificate be executed  A medical  Examiner  Medical  Examiner  Mofor use as the burial-transit	icai Examiner	Immigrate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consum of the	dequence of):  Lancer dequence of):  Lsion	y Arres	t				Onset and Death
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3 [	Ectopic pregnancy Other (specify)	′		23d. Date Mon	e of delivery	y Day Year
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Division of Vital	Attending Physicial in death. ector; After this certific by the funeral director.	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1  Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at	ome 5 Resid			
Divis	i te	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural I	Route Number,
	To the Hospitel within 24 hours a To the Funeral C completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	sician: To the best of my k ner: On the basis of exami and manner stated.	rnowledge, death ination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the d red at the time, o	ause(s) and mar date and place, a	ner as stat nd due to t	ted. he cause(s)
1	To To Sorr	Σ	29b. Signature and title of certifier	Dy.	M)	29c. Licens	8 15 2	4	29d. Date signed		ay, Year)
	(6)			SIT, MI) 12	21 Mer	•	Ln.Lar	go,MD.	20785		
	Sta Registr		NOV 2 4 2004	32. Registrar's Sig	nature						

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 5:59 PM John Edward Wesley November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year aug. 16, 19) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1₹M 2□F Georgia 98 Yrs. 578-18-4555 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County itam 27 is marked other than "natural", or Itams 23a or 28e-f show othar traumetic avant, the Mucical Examinar must be notified at 1 ⊈Yes 2 □ No Director D.C. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5101 F St., S.E. 20019 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. African Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 X Widowed 4 □ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5th College (1-4or 5+) Railroad Private 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be James Wesley Orea Stewart ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1836 Addison Rd., District Heights, MD Mary J. Evans - Daughter 20b. Place of Disposition (Name of page) k 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: ff any injury or once. Maryland National Mem. 11/26/04 Laurel, MD 4 □ Qonation 5 □ Other (Specify) Stewart Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service License 4001 Benning Rd., N.E. Wash., DC 20019 evoa Approximate Interval Between Onset and Death enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, br heart failure. List only one cause on each line. shock nugo Immediate Cause (Final disease or condition resulting in death) Acreci **Physician** /Medical Due to (or as a consequence of): **Examiner** 1+ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed page 2 XNo 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2× No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 2 🗌 No investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0024208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABYILH ASAN 0 31. Date filed (Month, Day, Year) State NOV 2 4 2004 Registrar

Alma Elizabeth white

			Please 1  For State Registrar	Type or Print in E State of Marylar	d / Depa	artme					
	Physici /Medio		1. Decedent's Name (First, Middle, Last Alma Elizabe					2. Date of Month	Death nber Da	18, 200°	4 7:50 PM
}	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or Location of	Death		. County of Dea	
			Doctor's Hospita		to a to trade of a co		nham er 1 Year   If Under 24	Hrs 0 Day of		Prince	
	Funeral Director		5. Social Security Number 578–20–9804 6. Se Usual Residence of Decedent		86 Yrs.	Months		Min. 8. Date of (Month, Oct.9	Day, Year)	C	thplace (State or Foreign ountry) hington, D.C.
	land ow		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Mary Field	to	Maryland Prince G	eorges Ca	apito1	Heig	hts				1⊠Yes 2 ☐ No
	38 or 28e	Funeral Director	10e. Street and Number 904 Highview Dr.				p Code 20743			tizen of What C nited S	
21215-0036	d within 72 hours after death with the Maryland jene. Ir than "natural", or items 23a or 28e-f show The Madical Examinat must be indiffied at	þ	11. Marital Status  1 Never Married 2 Married  3 🗷 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Dec If Yes, sp	edent of Hispanic Origin ecify Cuban, Mexican, I 2 x No Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Whi Specify: B1	te, etc.
ည	72 ho	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Us	ual Occupation ork done during most o	of working	16b. K	ind of Business	/Industry
7	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired) Manager	g	р	rivate	Business
2	e filed w Il Hygier other th		17. Father's Name (First, Middle, Last)		100	c car.		s Name (First, Mid			
ano		Be						a Stewar		i Sumame)	
2	should be I and Mental I marked o' umatic eve	은	Charles Reed  19a. Informant's Name/Relationship (7)	voe. Print)	19b. Maili	na Addre	s (Street and Number			or Town, State.	Zip Code)
Maryland	and 2 sealth ar n 27 is			on		_	reet N.E.				002
d)			20a. Method of Disposition	20b. I	Place of Dispo cemetery, crea	osition (Na	ame of other place)	Date	20c. L	ocation - City or	Town, State
Ë	Page nent o nt: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	nemoval hom State			emetery Nov	.24,2004	Bre	ntwood,	Md.
Baltimore,	permit. Pages 1 Department of H importent: if its any injury or ot once.		21. Signature of Funeral Service Lic n				ander S. Facility Mariboro			omes,Md	:A·20747
			23a. Part1: Enter the disease, or comp shock, or heart failure. List only of								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PHEL							Onset and Death
	/Medical		resulting in death)	Due to (or as a consec				***			
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687	phys phys s the		•	d							
.O. Box (	it the death certificate by the attending phys tached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)		-	23d. Date of de Month	olivery Day Year
Δ.	The law requires that the ate has been signed by the page 2 should be detache		Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	ınderlying	cause given in Part I.	23e. D	id tobacco	use contribute t	o the cause of death?
Records,	signed d be del	d by						1	☐Yes 2	<b>≥</b> No 3 □ P	robably 4 \( Unknown
CO	w require been si should I	Completed						24a. W	as an	24b. Were a	utopsy findings available
Re	The law cate has page 2 t	dmo						— au	utopsy erformed?_	prior to death?	completion of cause of
Vital	ician: Th certificate rector, pag	a	25. Was case referred to medical		<u> </u>		26. Place o	1 ☐ Ye f Death (Check on		1 □ Yes	s 2 No
<u> </u>	S 0 70	0 0	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 🗆 🗈	Other	ing Home 5□R		6 ☐Other (Spe	ecify)
οL		n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of	28c. Injury at Work?	28d. Descri	be how inju	ry occurred	
Ö	Attandin death. ctor: Af y the fur	atic	2 ☐ Accident investigation			М	1 ☐ Yes 2 ☐ No				
Division	after de Directe d in by t	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)	reet, facto	ry, office		n (Street ar Town, State		lural Route Number,
	To the Hospitei or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsicien: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurre ivestigation	d at the time, date and n, in my opinion, death	place, and due to to occurred at the tin	he cause(s ne, date and	) and manner a d place, and du	s stated. e to the cause(s)
	within the complex	Me	29b. Signature and little of confifier			2	c. License number		29d. Da	te signed (Mon	th, Day, Year)
	(6)		1/2/00	$\mathcal{X}$			DIZZ	94	11/	21/0	4
	Cilia		30. Name and address of person who c	ompleted cause of death (Itel	m 23a) (Type,	Print) L	R Colin OH	ey	7	,	
	ع الا		8118 GOOD mere	READ LA	WHO	non	why has	0 20	70	4	
	Sta Regist		31. Date filed (Month, Day, Year) . NOV 2 4 2004	25 WD LAN 32. Registrar's Sign	ature	'					

State of Maryland / Department of Health and Mental Hygiene 004

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 2004 **Physician** 1:10 p M BARBARA JEAN WAYBRIGHT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. MARY'S HOSPITAL LEONARDTOWN ST. MARY'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🔀 F Director 579-44-5176 JAN. 29, 1936 WASH., DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No MARYLAND ST. MARY'S MECHANICSVILLE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26300 MORGANZA 20659 TURNER RD. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event 2008. Be THOMAS CHARLES RICE EUNICE EDRIE YATES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES WAYBRIGHT, SR.-HUSBAND 26300 MORGANZA TURNER RD., MECH., MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHARLES MEM. GDNS.12-6-04 LEONARDTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final muelo du splaitic **Physician** Zmonins disease or condition resulting in death) /Medical 87 Rais Examiner Non Hodayins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): . Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by COLORECTAL CARLINOMA 1 Yes 2 No 3 Probably 4 Unknown SYNDROME SJOGREN 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy ANTHRIS performed' RHEUMATOID 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D50686 12/3/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 PT Lookout Rd Leonardtown Md 20650 Gurdeep s Cl 31. Date filed (Month, Day, Year) CHHABRA 32. Redistrar's Signature State BEC 0 8 2004 Registrar

			8	State of Ma	ryland / Depa <i>Cel</i>	artment of <i>rtificate o</i>		_		04	38942
	DI	•	Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
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ı	Funeral Director		234-20-1091	2X F 95	(In yrs. lest birthday) Yrs.	If Under 1 Yes Months Dey		n. (Month, Da	th ay, Year) 3, 1909	9. Birthplac Country WV	ee (State or Foreign ) ]
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d.	. Inside City Limits
	f sho	ō	MD GARRETT		OAKLANI	)					1 ☐ Yes 2 🎇 No
	ith the Merylan or 28e-f show	Funeral Director	10e. Street and Number		OAKLANI	10f. Zip Code	)		10g. Citizen of V	What Country	?
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	death	Jera		Was Decedent E	ver in U,S. 13.			(Specify Yes or No erto Rican, etc.)		æ - American	
21215-0020	hours after death with the Meryland ural; or Items 23e or 28e-f show al Expiritive must be rediffed at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🎞 Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No. If Yes, Give Year or Dates:	0	rYes, specify Cu I□Yes 2][[]N		erto Rican, etc.)		ck, White, etc. V: WHIT	
0	"netural",	E E	15. Decedent's Educat	ion	16a. Deced	lent's Usuel Occ	upation	vorkina	16b. Kind of B	usiness/Indus	try
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	s 1 and 2 should be filed within f Haalth and Mantel Hygiene. Itam 27 is marked other then other traumetic event, Ita M		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location -		State
Baltimore,	eges int of t: if it		1 N Burial 2 □ Cremation 3 □ Rem 4 □ Donetion 5 □ Other (Specify)	oval from State	cemetery, crem	netory or other p MFTFRV	lace)	11/30/04			,
Ħ	ortan		21. Signature of Funeral Service Licensee			. Name and Add	ress of Facility			-	
B	permit. Peges 1 and 2 Depertment of Haalth s important: if itam 27 is eny injury or other tra once.		10.4/1/1	+					BOX 243		
			23a. Part1. Enter the disease, or complicat	ions that caused t	he death. Do not ente			E - OAKLA ac or respiratory a		Ap	proximete
-	Physician		shock, or heart failure. List only one of	ause on each line	<b>3.</b>					Int Or	tervel Between nset and Death
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Division of Vital Records,	deeth deeth ctor: /	licat	2 Accident investigation 3 Suicide 6 Could not be	98e Place of Injur	y - At home, farm, stre			28f Location (5	Street and Number	er or Rural Ro	oute Number
Ďį	efter Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	ot, lactory, office	•	City or Tox	m, Stete)	or or ridiarire	ato mambor,
	To the Hospital or Attending Physicien: The law within 24 hours effect deeth.  To the Funerel Director: Attar this cartificate has complately filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)  1 Certifying Physicia 2 Medical Examiner:	n: To the best of On the basis of e	xamination and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to the courred et the time,	cause(s) and me date and place, a	nner as stated and due to the	d. e cause(s)
	vithin o the ompl	Me	29b. Signature end title of certifier			29c. Licer	nse number		29d. Date signed	d (Month, Dey	, Yeer)
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	^		30. Name and address of person who compl		ath (Item 23a) (Type. F	Print)	4) 1)	7 '	C DT/	-/,2	- /
	2		Walter K. Noum			0x 24	-7. Acc	ident	MDZ	21520	D .
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		1 - For State Registrar		State of	iviai y lai ic		rtificate of				Reg. No	noi.	3001.2
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Physi	cian dical	PATRICI	A DARI	ENE WI	NFIELD	•			И	OVEMB	ER 2	29,2°°°	7:13A M
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		Rt 220					RAWL		0411			LEGAN	
Funera		5. Social Security Num		ex 7. □M 2.23.F	Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		Min.	B. Date of Birt (Month, Da)	y, Year)		thplace (State or Foreign ountry)
Directo	or	218-62-7 Usual Residence of D			53_				C	oct 1,	195	1Ma:	ryland
yland		Most	0b. County		10c. City,	Town or Lo	ocation						10d. Inside City Limits
a-fal	cto	Virginia	Miner	al	Ri	dgel	ev						1 ☐ Yes 2√2 No
ith the	Oire	10e. Street and Numb				_	10f. Zip Code					en of What C	ountry?
ath w	by Funeral Director	Rt 3 Box	445	10 W- D			267		i-i-2 /C=	H. Van as Na		SA 4. Race - Am	ndona Indian
er de Items	une	11. Marital Status  1 Never Married	357 Marriad	12. Was Deced Armed Ford 1 ☐ Yes 2	es?	5. 13.	Was Decedent of If Yes, specify Cul	oan, Mexicar	n, Puerto R	ican, etc.)		Black, Whi	
336 urs aff	by F	3 Widowed 4		If Yes, Give Year or Date			1 ☐ Yes 2 🛣 No	Specify:	•			Specify: \[	White
ore, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland if saths and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other treumatic avent, the Medical Examinar must be notified at	Completed		5. Decedent's E		-	16a. Dece	dent's Usual Occu	pation	st of working	7	16b. Kir	nd of Business	/Industry
215 Febrary 1	npie	Elementary/Second	, ,	College (1-4	or 5+)		kind of work done DO NOT use retire ral Car				Dog:	t Off:	
led wi	Cou	12	and Adiabatic America	5+					or's Namo	(First, Middle,			ice
be fill H ad out	Be	John R.								an Wa			
arylano should be and Mental s marked o	ို	19a. Informant's Nam				19b. Maili	ng Address (Stree	<u> </u>					Zip Code)
Ma d 2 s th an trau				•	ishand		-					26757	
re, N s 1 and Health tam 27 other tr		Glenn W				ace of Dispo	osition (Name of matory or other pla	ace)	Da	ite Y +	20c. Loc	cation - City or	Town, State
Baltimore, I permit. Pages 1 and Department of Heali important: if itam 2 any injury or other		1 ☐ Burial 2 🔀	Cremation 3 ☐ ☐ Other (Specif	]Removal from St fy)			gh Crema		Dec	5,200	4 Ur	nionto	wn, PA
Baltil permit. I Departm importa	á	21 Signature of Fune	ral Service Dice	nsee	0		2. Name and Addr						
m gg E	ä	0	reato.	- XT	La	) Ha	ifer Fu	neral	. Ser	vice,	PA		
		23a. Part1. Enter the shock, or heart	disease o com failure. List only	plications that car one cause on eac	used the death. ch line.	. Do not en	ter the mode of dy	ing, such as	cardiac ar	respiratory ar	est e '	, MD 2	Interval Between Onset and Death
Physicia		disease or condition	nal	a Mu	LLtio	le-	Niu	ries	Ŝ.				Oriset and Death
/Medica		resulting in death)	•	Due to (o	ras a consequ	ence of):	7						
LAdmin		Saquantially list cond	itions	b. Due to (o	r as a consequ	ence of):					-		
ted is	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or in	ring lury	200 (0	45 4 50.15542	2.100 01).							
760, A.A. be executed sician and burial-transit	Exar	that initiated events resulting in death) La		c. Due to (o	r as a consequ	ence of):							
760, te be exe ysician a	cai			_ d									
68 tiffica g ph as th	Medi	THE PERMIT							F1-51		-		
Box eath cert attendin for use	an/h	23b. Was decedent p			th 2 Fetal	death 3[	⊒Ectopic pregnan	су			2	3d. Date of de Month	livery Day Year
	Physician/Medi	1 Yes 2 1		4□Pregna 9□ Unknov	nt at time of de vn	ath 5	Other (specify)						<b>54,</b>
ords, P.O. requires that the d een signed by the rould be detached			ant conditions	contributing to dea	th but not resu	Iting in the u	inderlying cause g	ıvən in Part I	E.	23e. Did to	obacco u	se contribute t	o the cause of death?
	þ			· ·						101	Yes 2	No 3□P	robably 4 🗀 Unknown
	ompieted	4								24a. Was	an	24b. Were a	utopsy findings available
Fec The law ate las b	E	1									rmed?	prior to death? 1 <b>X</b> Ye.	completion of cause of s 2 No
Vital F ician: Th certificate rector, pag	O	25. Was case referre	d to medical		·			26. Place	e of Death	(Chéck only o		1/24 10	20110
of Vita Physician: this certific ral director,	ToB		0	Hospital: 1 ☐ In	patient 2 🗆 E	ER/Outpatie	nt 3 DOA	ther: 4 🗆 N	ursing Hom	e 5 Resid	dence 6	Other (Spe	ecity) SCENE
			5 Pending	28a. Date of	Injury Day Year)	28b. Time o	Cour 28c. Inju	ury at	21	Bd. Describe I	now injury	occurred M.A.	for which
Vision Attending r death. ector: After	atic	2 Accident	investigatio		-04	65	1 M 1	Yes 2	-	activi	acci	dent	101 1011010
Division  I or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	200. Flace	of Injury - At hor g, etc. (Specify	me, farm, st	reet, factory, office	,	2	City or Toy	vn, State)	- 00	at Toms Holly
pita urs srai			☐ Certifying P	hysician: To the t		OV V	b occurred at the	time date ar	nd place, as	RODE	Cause(s)	Lawin	195 MD
To the Hos within 24 ho To the Fund completely f	edical	(Check only 2	Medicel Exa	miner: On the bas	is of examinati	ion and/or ir	nvestigation, in my	opinion, dea	ath occurre	d at the time,	date and	place, and du	e to the cause(s)
Fo the Mithin Fo the	Z	29b. Signature and til	tle of certifier	7	7	7	29c. Licer	se number		1		-	th, Day, Year)
, , , ,		1 Tax	6	Cronis	a-1	alla	0	C M	E	direction of the second	NOVI	EMBER	30, 2004
		30. Name and address	s of person who	completed cause	of death (Item	23a) (Type	Print)					-5-5	
	6	PAtric	IA Ar	ONICA	- Poli	14 1L K	(D) 111	PENN	STR	EET, B	ALT	MORE,	MD 21201
	State istrar	31. Date filed (Month	FO .	2004	gistrar's Signat								
neg	edici.		0 / /	4004	paper		box	the !					

			1 - For State Registrar	of Maryland / Dep <i>Ce</i>	artment of Health and rtificate of Death	Mental Hygie	2004	38944
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		George Donald Yeakle			NOVEMBER	25 2004	2004 M
	Examin		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Deal	h	4c. County of Death	
			Washington County Hos		Hagerstown If Under 1 Year If Under 24 Hrs	10.5(5:1)	Washing	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Months Days Hours Min.	(Month, Day, Yo	ear) Cou	
	Director		Usual Residence of Decedent	/4		Nov. 29,	1929 Mar	yland
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-f si	ctor	Maryland Washington	Hagerst	own			1 ☐ Yes 2 ☒ No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	ntry?
	ath w		12324 Walnut Point Wes		21740		USA	
	er de Itams	Funeral	Armed	Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
36	I', or	by F	1 ☐ Never Married 2 ☑ Married 1 ☑ Ye If Yes, 3 ☐ Widowed 4 ☐ Divorced Year or	s 2 □ No 1951 – Give Dates: 1953	1 ☐ Yes 2 🛣 No Specify:		Specify: Wh	ite
Ö	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show grifcel Evaluiter meat be collined at		15. Decedent's Education	16a. Dece	dent's Usual Occupation	, 16	b. Kind of Business/Ir	dustry
215	C - 3	pie	(Specify only highest grade complete Elementary/Secondary (0-12) College	(Give life.	kind of work done during most of wo DO NOT use retired)	rking		
21	filed within Hygiene othar than	Completed	8		er and Crater		lircraft I	ndustry
nd	be filed within that Hygiene. Id other then event, the M	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Mai		
Maryland 21215-0036	nd 2 should be f lith and Mental H 27 is markad of r traumatic eve	P	John R. Yeakle			atilda Clo		2 ( )
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ri			
	tha E		Anne C. Yeakle/Wife  20a, Method of Disposition	20b. Place of Dispo	4 Walnut Point We		c. Location - City or T	
Baltimore,	S to		1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal fro  4 ☐ Donation 5 ☐ Other (Specify)	m State	matory or other place) en Cemetery 11/3	0/2004 На	acratorm	Marriand
Ħ	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Re			
B	permit. Departr importa any inju		> S. Muli Sum		601 Pennsylvania			•
			23a. Part1. Enter the disease, or complications that shock, or heart lailure. List only only cause of					Approximate Interval Between
300	Physician		Immediate Cause (Final disease or condition	Coronary	Artary D	iscasa	_	Onset and Death
	/Medical		resulting in death)	o (or as a consequence of):		111		
	Examiner		Sequentially list conditions, b	Cirrhos	5 0 1	111		
V	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):	es meliti	A S		
	be executed sician and burial-transit	xan	that initiated events c.	o (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dicai E	d				1	
89	ifficate g phy as the	edic	J					
Вох	death certifica e attending ph ed for use as t	M/M	23b. was decedent pregnant	outcome of pregnancy birth 2 Tetal death 3	Ectopic pregnancy		23d. Date of deliv	
	υ ψ ω	Physician/Me	1 Yes 2 No	gnant at time of death 5	Other (specify)		Month	Day Year
P.O	that the de led by the a detached i	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to		adorhing as use gives in Part I	23e Did tobac	co use contribute to t	he cause of death?
JS,	Se 25 90	by	Part II. Other significant conditions continuously to	death but not resulting in the t	noenying cause given in rait i.	1 Tes		
Vital Record	w require been si should t	ompieted						•
Rec	has e 2	mpi				24a. Was an autopsy performed	prior to co	ppsy findings available mpletion of cause of
a	ian: The rtificate stor, pag	e Co	25. Was case relerred to medical		as Place of Do	1 ☐ Yes 2, ☐ ath (Check only one)	No 1 □ Yes	2□ No
⋚	Physician: this certific ral director,	0 8	examiner? Hospital:	Inpatient 2DER/Outpaties	Other	Home 5 ☐ Residence	a 6 ⊟Other (Specia	(v)
ot	g Ph) er thi	n: T	27. Manner of Death 28a. Da	e of Injury 28b. Time onth, Day Year) Injury		28d. Describe how i		,,
ioi	Attanding ir death. actor: After by the fune	atio	2 Accident investigation	milary	M 1 Yes 2 No			
Division	l or Atta atter de Diracto I in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pta bu	ce of Injury - At home, farm, still Iding, etc. (Specify)	eet, factory, office	28l. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	urs aft ral Di			1				
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examiner: On the	he best of my knowledge, deat basis of examination and/or in anner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	. L	29c. License number		Date signed (Month,	
			fame min	~\	D006039	76	11/2/1	7 9
	5		30. Name and address of person who completed co		1126 Oral C	suict 17	19. Md	21742
	Sta Registr		31. Date filed (Month Pay Year) 32	Registrar's Signature	Loads			

GEORGE DOMPLD YEARLE

		For State Registrer	State of Mary		artment of I <i>rtificate of</i>			giene 0 0	4 38945
Physici	ian	Decedent's Name (First, Middle, Last	Helen		Allen		2, Date of Dea Month		a. Time of Death
/Medic Examir		Bertha  4a. Facility Name (If not institution, give	street and number)			or Location of Death		4c. County of N/A	
Funeral Director		Bayview Geriatic  5. Social Security Number  212-28-2510  6. Social Security Number		yrs. last birthday,			8. Date of Birtl (Month, Day January	h   0	Birthplece (State or Foreig Country) MD.
show	Ļ	Usual Residence of Decedent  10a. State 10b. County		c. City, Town or L					10d. Inside City Limit
or 28a-f	Directo	MD. Baltimo		Essex	10f. Zip Code	221		10g. Citizen of Wha	
iene. r then "natural", or tems 23a or 28a-f show It in Medical Examinat intralate modified at	y Funeral Director	523 Brighton Plac  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give	r in U.S. 13.	Was Decedent of h	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc. White
Aedic	Completed by	3 XWidowed 4 □ Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)	year or Dates:	(Give	DO NOT use retire	during most of word)		16b. Kind of Busin	ness/Industry
T the	Be Com	7 Years 17. Father's Name (First, Middle, Last)		Ass	sembly Li		ne (First, Middle,	Bendix Maiden Sumame)	Company
nd Mer marke	Tol	Frank Pasek  19a. Informant's Name/Relationship (7)	ype, Print)			and Number or Ru		r, City or Town, Sta	nte, Zip Code)
item 2 item 2 other		Beverly Baron  20a. Method of Disposition  15 Burial 2 Cremation 3 Cremation 5 Other (Specify	Removal from State	Ob. Place of Disponentery, cre		, Dece	Date ember	21221 20c. Location - Cit Rosedale	
Department of Important: If any injury or once.		21. Signeture of Funeral Service Licen	Correl	Ply ?	Name and Addre Connelly 7110 Soll	Funeral I ers Point	Home of I t Road, 1	Dundalk,F Dundalk,M	P.A.
nysician		23a. Pert1. Enter the disease or comy shock, or heart failure. Ust only Immediate Cause (Final disease or condition resulting in death)	lications that caused the one cause on each line.	death. Do not en	ter the mode of dyin	ng, such as cardiac + Fai	or respiratory are	rest,	Approximate Interval Between Onset and Death
e attending physician and parties as the buriat-transit	ledicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	verten	rsion				10425
by the attending photached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date o Month	f delivery Day Year
been signed by should be deta	by	Part II. Other significant conditions of	ontributing to death but no	1.1	inderlying cause given 2 of Hyra		23e. Did to		ite to the cause of death?
ate has page 2	Completed						24a. Was a autop perfor 1 Yes	sy prio med? dea	e autopsy findings available to completion of cause of the Yes 2 No
this certific	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3□ DOA Ott	200 12 12 12 12 12 12 12 12 12 12 12 12 12	th (Check only or	ence 6 Other	(Specific)
After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. Inju Wo			ow injury occurred	Эрвену
s after death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
within 24 hours after of To the Funeral Direct completely filled in by	ledical		ysician: To the best of m iner: On the basis of exa and manner stated.	mination and/or in					
within 2. To the I	Me	29b. Signature and title of certifier	2.1.1		29c. Licens			29d. Date signed (A	
10		marther	US Cottone	> m	D	4575	7	Diec S	12087
1,			10 Megra	7 494	to Ens.	tem An	e BA	1 trave	12004 MD 21220
Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's	Signature &	horse	51			

ORIGINAL

			1 - For State	State of Maryland		t of Health and e of Death		71111	38946
	Physici	an	Registrar  1 Decedent's Name (First, Middle,	Last)	Ochimoate	or Death	2. Date of Death	Day Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution,	ADOOYIN	4h Cihi	Town, or Location of Deat	DECEMBE	R 03 2604	
	Examir	ner	Union Men	norial Hospi	ital Br	1 40 -	n	4c. County of Death	1
	Funeral Director	6	5. Social Security Number  2/7-50-/66  Usual Residence of Decedent	7. Age (In yrs last	Yrs. Trunder Months	1 Year If Under 24 Hrs Days Hours Min.	_ O. Dato of Siltin	47 No	nplace (State or Foreign untry)
	show dat	_	10a. State 10b. County	City, T	own or Location				10d. Inside City Limits
	the Ma	Director	10e. Street and Number	Da	17 mc	•	100	Citizen of What Cou	1 XYes 2 No
	23a or		2305 ROL	1 Street	2	1218	(	ISA	aridy:
"	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No	13. Was Deced If Yes, spec	ent of Hispanic Origin? (S ify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene.  do other then "natural", or Items 23a or 28e-f show event, the Medical Everting trunst be redified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2			Specify: B	aclo
215-	withIn 72 ene. then "nat	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education 1- grade completed)  College (1-4or 5+)	6a. Decedent's Usua (Give kind of work life. DO NOT us	k done during most of wor	king 16t	. Kind of Business/li	ndustry
	filed with Hygiene. Ither ther			4 years.	Social	WORKE	R S	ocial.	esuices
Maryland	should be formally marked of	To Be	Rober+Isia	h Falmer		Eve 1	ne (First, Middle, Mai	den Sumame)	-
Mary	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship	/	19b. Mailing Address	(Street and Number or Bu	ral Route Number, Ci	ty or Town, State, Zi	p Code)
	1 an Heal em 2 ther		20a. Method of Disposition		e of Disposition (Nametery, crematory or of	le of her place)	Date 200	Location - City or T	own, State
Baltimore			Magazia 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	city)	itus en	etery 12/	11/04B	Atimo	re MD
Bal	permit. Pag Department Importent: I any Injury o		21. Signature of Furieral Service Lie	ensee	12 Name and	Address of acily	ene Fre	veral S	ervices P.A.
			23a. Part1. Enter the disease, or co shock or heart failure. List or	omplications that caused the death. Daily one cause on each line.	Do not enter the mode	of cyling, such as cardiac	or respiratory arrest,	ADMU 1	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a DISSEMINA	ATED IN			GIULATION	Onset and Death  24 Hours
	Examiner		Conversion links and dataset	b. META STATIO	ŕ	ST CANC	ER		6 MONTHS
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):				6 7 10 10 11 13
o,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequence	ce of):				
8760,	cate be e. physician the buria	dical		d					
Box 6	leath certifice attending ph I for use as th	ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of deliv	ery
O. B	the the	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown				Month	Day Year
<u>a</u>	res that the igned by be detact	by Ph	Part II. Other significent conditions	s contributing to death but not resulting	g in the underlying ca	use given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
Records,	w require been sig should b	eted t					1 ☐ Yes	2□No 3□Prol	bably 4 <b>∮⊠</b> Unknown
Rec	e la has	Completed					24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
Vital		Be Co	25. Was case referred to medical examiner?			26. Place of Dea	1 X Yes 2 ☐ th (Check only one)	No 1 ☐ Yes	2 <b>%</b> No
of	Phys this raldii	은	1 ☐ Yes 2 ☑ No  27. Manner of Death		Outpatient 3 DOA		ome 5 Residence		(y)
	Attending Phy r death. ector: After thi by the funeral o	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Year)	Injury M	c. Injury at Work? 1 DYes 2 No	28d. Describe how in	njury occurred	
Division	or Atterder de Directo	Certification:	3 Suicide 6 Could not 4 Homicide determine		, farm, street, factory,	office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying	Physician: To the best of my knowled	dge, death occurred a	t the time, date and place,	and due to the cause	e(s) and manner as s	stated.
	the Ho hin 24 the Fu	Medical	(Check only 2 Medical Exone)  29b. Signature and title of certifier	aminer: On the basis of examination and manner stated.	and/or investigation, i	n my opinion, death occu	red at the time, date a	and place, and due to	o the cause(s)
	2 1 K 2		250. Signature and time of certain	menion ave	M 296	24389V	290.	Date signed (Month,	02 2004
	15			o completed cause of death (Item 23a	a) (Type, Print)	1111			Day, Year) 03, 2004 e, MD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	ion Mem	orlal Hosp	rital B	paltimor	e, 11(1)
	Registr		DEC 0.9	2004 Benera	B 60	acti			

			1 - For Registrar	State of Maryla		ent of Healti	h and Mental Hy	/giene 0 0 4	38947
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Later Company)     Aa. Facility Name (If not institution, given the company)	Hda	ms	City, Town, or Locati		eath Day Year	3. Time of Death
	Funeral Director		Usual Residence of Decedent	□M 2×1 €	88 Yrs. Mont	oder 1 Year   If Uni	der 24 Hrs. 8. Date of Bi (Month, D.	irth ay, Year) 9. Birth Col	place (State or Foreign intry)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be routiled at once.	To Be Completed by Funeral Director	10a. State 10b. County  10a. Street and Number  10b. Street and Number  10c. Street and Number  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Er (Specify only highest grave)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (10c)  10 Burial 2 Cremation 3 County  10 Burial 2 Cremation 3 County  10 Burial 2 Cremation 3 County  11 Signature of Funeral Service Licenty  20a. Part 1: Enter the disease, or compared to the county of the county	12. Was Decedent Ever in Armed Forces?  1	U.S. 13. Was During In the Internation of Internati	Zip Code  2	nost of working  ALEN  Ther's Name (First, Middle  LLEN  Ther or Rural Route Numb  Date  Cility CROMPATA  STORY STORY	Specify: 3	ican Indian, etc.  INCK INCK INCUMANTALE INCOME INC
8760,	death certificate be executed  Example attending physician and ior use as the burial-transit	ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or acc. Due to (or acc. Due to (or	quence of):	Ence Nelli	phalop	3thy	Approximate Interval Between Onset and Death
P.O. Box 68	the death certifica y the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □Ectopi	c pregnancy (specify)		23d. Date of deliv Month	ery Day Year
Vital Records, P.	: The law requires that the decate has been signed by the page 2 should be detached	Completed by Ph	Pan II. Other significant conditions of	ascular	sulting in the underlyin	g cause given in Pa	1 24a. Was autor perio	an 24b. Were auto	he cause of death?  pably 4 20 Unknown  posy findings available mpletion of cause of  22 No
Division of Vita	To the Hospitel or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	ertification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At houlding, etc. (Special Control of the Control of th	28b. Time of Injury M	DOA Other: 480 28c. Injury at Work? 1 \( \text{Yes} \) 2	□No	dence 6 Other (Special how injury occurred	
۵	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	Medical Cer	29a. Certifier (Check only one)  Cartifying Physics Madical Examone)  29b. Signature and title of certifier	vsicien: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date ion, in my opinion, d	and place, and due to the eath occurred at the time,	cause(s) and manner as s date and place, and due to 29d. Date signed (Month,	Day, Year)
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	Sta Registr		DE'C'0' 9' 200	32. Agistrar's Sign	& A	sa de			

			1 = For State Registrar		State of Ma	arylan	d / Depa <i>Cei</i>	artment of I rtificate of	lealth Deat	n and M Th	lental H	ygien Reg. N	e20	04	38948
	Physic	an	1. Decedent's Name (First, M	ddle, Last)	)						2. Date of D		ay	Year	3. Time of Death
1	/Medi				ı Louise	Воу	rd				Decemb	er 8	3, 200	)4	12:48 P <sup>M</sup>
	Examir	ner	4a. Facility Name <i>(If not institt</i> )					4b. City, Town, o				4	c. County o		
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ш	Funeral Director		220-30-0768		]M 2XF	71	Yrs.	Months Days	Hour	s Min.	JUL 27	ay, Year	933		lace (State or Foreign try) Siana
	pur *		Usual Residence of Decedent 10a. State 10b. Cou	nh.		10c City	, Town or Lo	eation							
	anylan show	JO.		į		TOG. City	, TOWN OF LC							11	0d. Inside City Limits  XXYes 2 □ No
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	death	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S	S. 13.	Was Decedent of H		Origin? (Spe	cify Yes or N	0-	14. Race	- Americ	
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lary	2 short		19a. Informant's Name/Relati	onship (Ty	pe, Print)		19b. Mailir	ng Address (Street	and Nun	nber or Rura	l Route Num	ber, City	or Town, Si	tate, Zip	Code)
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Baltimore,	Pages 1 ment of H ant: If ite ury or otl		20a. Method of Disposition  1 Burial 2 Cremati	on 3 □R	lemoval from State	CE	metery, crer	sition (Name of natory or other pla		l	ate		Location - C		
퍜	+ t t = .		' 4 ☐ Donation ' 5 ☐ Othe  21. Signator of Funeral Serv	(Specify)		Met		ematory,					altimo	ore,	MD
Ba	Depa Impo any ii		Edward A.	drego	orchik			Name and Address remation 99 Freder	TICK	_KOau	ватели	ore,	MD	2122	28
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O. Bo	0 0 0	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1□Live birth 4□Pregnant at 9□Unknown			Ectopic pregnancy Other (specify)	y 				Month		Day Year
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of \	di S	ဥ	1  Yes 2 10 10	-			R/Outpatien		4 🗀	-	ne 5 Ares				)
	ng fter ine	tion:	27. Manner of Death 1 ☐ Natural 5 ☐ Per		28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2		8d. Describe	how inju	iry occurred		
Division	Attsnding r death. ector: After by the fune	ficat	3 ☐ Suicide 6 ☐ Coi	stigation Id not be mined	28e. Place of Inju	ry - At hor	ne, farm, str		165 21	1	8f. Location	Street a	nd Number	or Rural	Route Number,
Ö	s after	Certification:	4 Homicide		building, etc	. (Specify)	}	,,			City or To	wn, Stat	e)		,
	To the Hospital or Attandi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier 1 Certi (Check only 2 Medione)	ying Phys	sician: To the best oner: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred at the tir restigation, in my o	me, date ppinion, d	and place, a eath occurre	nd due to the	cause(s date an	s) and mann od place, and	er as sta	ited. the cause(s)
	To th To th comp	Me	29b. Signature and title of cer	ifier		, 0		29c. Licens					ate signed (i		
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1	17		30. Name and address of pers	on who co											
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	Sta Registi		31. Date filed (Month, Day, Ye	ZUU4	•		/								

			For State Registrar	State of Ma	ırylan	d / Dep <i>Ce</i>	artment of F rtificate of	lealth and <i>Death</i>	l Mental H	ygien Reg. N	200	4	38949
P	hysici	an	1. Decedent's Name (First, Middle, Last	)					2. Date of I			Year	3. Time of Death
	/Medic	al	Thomas Price 4a. Facility Name (If not institution, give				# 05 T		Novemb	per 2	27, 20	004	6:00 P M
ŀ	Examin	ier	Washington Adven		. 4 1		4b. City, Town, o		atn		c. County o		
Fu	ıneral		5. Social Security Number 6. Se		(In yrs. I	ast birthday,	If Under 1 Year Months Days	If Under 24 H		Birth Day, Year	Monto	9. Birthp Cour	place (State or Foreign
	rector		217-36-4771 Usual Residence of Decedent	JW 201	65	Yrs.					000		yland
yland	how		10a. State 10b. County		10c. City	, Town or L	ocation					1	10d. Inside City Limits
e Mai	Ba-f s	Director	Maryland Harford		Ве	el Air							1 ☐ Yes 25€ No
with th	a or 2	Dire	10e. Street and Number	- J			10f. Zip Code			10g. C	itizen of Wh	nat Cour	ntry?
death	ms 23	Funeral	1308 Tollgate Ro	12. Was Decedent E	ver in U.	S. 13.	Was Decedent of F	lispanic Origin?	(Specify Yes or I	No-	USA 14. Race	- Americ	an Indian.
U KIKISTONOS filed within 72 hours after death with the Maryland Hygiene.	itam 27 Is markad othar than "natural", or Itams 23a or 28a-1 show othar traumatic evant, the M. cical Examinar could be multified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	o		If Yes, specify Cub. 1 ☐ Yes 2 ☑ No	Specify:	erto Rican, etc.)		Black, Specify:	White,	etc. nite
72 ho	natur	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Dece	dent's Usual Occup	ation	vorkina	16b. h	Kind of Busi		
within ane.	than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retire	d)					
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2 should be filed within and Mental Hygiene.	arkad atic ev	To B	James Howard 1	Broumel				Sara	Ellen	Stea	rns		
2 sho	raum raum		19a. Informant's Name/Relationship (7)	rpe, Print)		19b. Maili	ng Address (Street	and Number or i	Rural Route Num	ber, City	or Town, Si	tate, Zip	Code)
s 1 and 2 of Health	tam 2		Barbara A. Broume  20a. Method of Disposition	l /Wife	20b. PI	130	8 Tollgat	e Road,	Bel Air		rylan ocation - C	d 21	014
Pages tment of	nt: Hii ny or o		1 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State			matory or other place. 's Episco	1	-3-04			•	
mit.	Importa any inju once.		21. Signature of Funeral Service Licens		DC.		2. Name and Addre			AD 7	шуао.	11, 1	Maryland
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			23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final	ication mat odused ne cause on each lin	the death e.	. Do not en	ter the mode of dyir	ig, such as cardi	ac or respiratory	arrest,			Approximate Interval Between Onset and Death
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Physici	his ce Il direc	To B	18 185 2 NO	łospital: 1 🗆 Inpatier		ER/Outpatier	nt 3 DOA Oth		Home 5 ☐ Res		6 Other	(Specify	·)
ding	After t funera	ion:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	Wor		28d. Describe	how inju	ry occurred		
Attand r deatl	actor: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At hor	me, farm, str		Yes 2□No	28f. Location	(Street ar	nd Number	or Rural	Route Number,
ital or	ral Dir		4 Homicide determined	building, etc.	. (Specify,	)			City or Te	own, State	a)		
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier To Certifying Phy (Check only one) 2 Medical Exemi	sicien: To the best of ner: On the basis of and manner stat	examinati	vledge, deat ion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the curred at the time	a cause(s , date and	) and mann d place, and	er as sta d due to	ated. the cause(s)
N E	COL	Σ	29b. Signature and title of certifier	ND			29c. Licens 448			29d. Da	te signed (/	Month, D	Jay, Year)
			30. Name and address of person who co	moleted cause of de	ath (Item	23a) (Type				11	1281	10,	
12+	1		Humayun Ze	y-MD.	760	O Car		Talcan	n Park	m	δ, ,	209	1/2
F	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 9 2004	32. Registra	r's Signati	ure &	Sparks	/					

State of Maryland / Department of Health and Mental Hygien 2 🛭 🗎 📗 38950 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Howard L. Brown, Jr. December 2, 2004 **Physician** 9:50 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Yrs 216-12-7690 Director March 7. Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be exititled at Md. Harford Joppa Director 1 ☐ Yes 24 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Brookwood Drive 21085 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. white þ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years mechanic elevator company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mil. Pages 1 and 2 should be fill partment of Health and Mental Hyportant: If Item 27 is marked oth y injury or other traumatic event Be Howard L. Brown, Sr. Alverta G. Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maggie Parker/daughter 5433 Broadway Road, White Hall, Md. 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gdns. 12/6/2004 Fallston, Md. 4 □ Donation 5 □ Other (Specify) permit.
Departr
Import 21. Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup> Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Recurrence of parotid gland tumor Jeans /Medical resulting in death) Due to (or as a consequence of): Examiner 1007,10 Lung metastasis Sequentially list conditions, Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Con estive heart failure and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical 1 wee Aspiration pneumonia as the IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the and to detached to 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 查Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 🗆 Yes 2. No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 A Nursing Home 5 Residence 6 Other (Specify) funeral dir ٢ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 MD 12/7/2004 D26191 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Joseph Angelo, 602 S. Atwood Road, Bel Air, Md. 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

nfr. ng

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State	State of Mary	/land / Dep	artment of I	Health and	Mental Hyg	liene2 0 0	38951
	Physici	an	1. Decedent's Name (First, Middle, Las	it)	Ce	rtificate of	Death	2. Date of Dea Month	eg. No.	3. Time of Death
	/Medic	al	JOSEPH FRANCIS I 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	DECEMBE	R 2, 200 4c. County of	
			LAUREL REGIONAL 5. Social Security Number 6. Securi		n yrs. last birthday)	LAUREL If Under 1 Year	If Under 24 Hrs	O Date of Right		GEORGES
	Funeral Director		208-42-9778	25 M 2□F 53		Months Days			Year) , 1951 Pi	n. Birthplace (State or Foreign Country) ENNSYLVANIA
	death with the Maryland ims 23a or 28a-f show contains the notified at	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Le	ocation				10d. Inside City Limits 1 📉 Yes 2 □ No
	the Ma	Director	MD PRINCE G	EORGES	LAUREL	10f. Zip Code		1	0g. Citizen of Wha	
	23s or	ralDi	13916 SHANNON AVE	NUE		20707			U.S.A.	
	should be filed within 72 hours after death with the Marylan and Mental Hygiene. Indexed other then "netural", or items 23s or 28s-1 show imarked other then "netural", or items 23s or 28s-1 show imaric event, the Maulical Exercises must be rediffed at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No		Specify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. WHITE
Maryland 21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occu	during most of wo	rking	16b. Kind of Busin	ness/Industry
1212	d within piene. r then	omp	Elementary/Secondary (0-12)	College (1-4or 5+) 4		DO NOT use retire HEMIST	od)		WALTER I	REED HOSPITAL
nd Ind	be filed Ital Hyg Id offhe event,	Be	17. Father's Name (First, Middle, Last)	TI				me (First, Middle,	Maiden Sumame)	
	should ind Men ind Men ind marke umaric	ဥ	ALBIN BARTOSEVIC		19b. Maili	ing Address (Stree		A KOPCHII		ate, Zip Code)
, <b>M</b> a	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		ROSE MARIE BARTOS	EVICH	139	16 SHANNO	N AVENUE	LAUREI	. MD 207	
Baltimore,	permit. Pages 1 and 2: Department of Health ar important: If item 27 is any injury or other trau		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☒  '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, cre CALVARY	matory or other pla	12-0		DRUMS , PA	•
	epartme epartme sportar ny injur	1	21 Signature of Juneral Service Licen		2:	2. Name and Addre	ess of Facility $FL$	ECK FUNE	RAL HOME,	,INC.
6	40 E 3 a		23a, Part 1, Enter the disease, or comp	LWWT				RD. LAURI		0707 Approximate
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart hailure. List only Immediate Cause (Final disease or condition resulting in death)	a. PULMONAR	Y EMBOLI:					interval Between Onset and Death
	Examiner		Conventially list conditions	Due to (or as a co	onsequence of):					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):					
	ite be executed lysician and he burial-transit	icai	that initiated events resulting in death) Last	Due to (or as a co	onsequence of);					
. Box 68	death certificate e attending phy od for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	-
P.O.	d by the	Phys	9 Unknown	9⊡ Unknown	es anno Miles (n. Miles			age Didas		4
rds,	w requires that the de been signed by the should be detached		Part II. Other significant conditions of MULTIPLE		ot resulting in the u	inderlying cause gr	ven in Part I.			ute to the cause of death?  Probably 4 Dunknown
Rec	The lay ate has page 2	Completed						24a. Was a autops perform	y prio ned? dea 2 X No 1 □	re autopsy findings available ir to completion of cause of th?  Yes 2  No
<u> </u>	90 (6)	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Outpatie	nt 3 DOA Ot		ath <i>(Check only on</i> dome 5 ☐ Reside		(Specify)
o uo	al or Attending Physician: atter death. i Director: After this certification by the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Wo			ow injury occurred	
DIVIS	i Sitte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number ( n, State)	or Rural Route Number,
	To the Hospital (within 24 hours all to the Funerel Dompletely filled in	Medical	29a. Certifier 1 XCertifying Ph	ysician: To the best of m iner: On the basis of exa and manner stated	amination and/or in	h occurred at the ti	me, date and place opinion, death occu	a, and due to the ca arred at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the h within 24 To the F complete	Med	29b. Signature and title of certifier	And mainer stated		29c. Licens		2	9d. Date signed (A	Month, Day, Year)
,	11		> / Males	Sulleus	dans	D24	093		DECEMBE	IR 3, 2004
1	1'		30. Name and address of person who of MARK PARKHURST, M				RDALE, M	0 20737		
	Sta Reģistr	_	31. Date filed (Month, Day, Year) DEC 0 9 2004	32. Registrar's		parks				

			For State Registrer	State of M	<b>1</b> arylan			nt of H		d Me	ntal Hy	giene	11111		38952
	Physicia		Decedent's Name (First, Middle, La NEENA BH	ATNAGAR		7					Date of De Month				3. Time of Death 8:00P M
	/Medic Examin	_	4a. Facility Name (If not institution, given	re street and number	r)		4b. City	, Town, or	Location of De		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4c	. County of E		0.001
			12201 GALESVIL	LE RD.			GA	ITHER	SBURG				MONTGO	OME	RY
E	Funeral Director			Sex 7. A 1 □ M 2 1 F	73	last birthday) Yrs.	If Und	Days	If Under 24 H	lin.	. Date of Bir (Month, Da DEC. 1	th ay, Year) 2 19	9. 31 BO	Birthpi Coun MBA	lace (State or Foreign try) Y, INDIA
	pu »		Usual Residence of Decedent		10- 01	-									
	shov	_	10a. State 10b. County		Too. City	y, Town or Lo	cation							110	0d. Inside City Limits 1 ☐ Yes 2 X No
	Ne M	Director	MD MONTGOM	ERY	G.	AITHERS					1				
	death with the Maryland ms 23a or 28e-f show rmust Le t. diffed at		10e. Street and Number				10t. Z	p Code	0			-	izen of Wha		try?
	eath	era	12201 GALESVILL  11. Marital Status	E RD.	t Ever in U	S 13 V	Vas Dec	2087	Spanic Origin?	(Specif	h, Vae or No		U.S.A.		an Indian
30	filed within 72 hours after death with the Marylan thygiene. the than "natural", or items 23a or 28e-1 show ont, the Medical Examination at codified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces  1  Yes 2X  If Yes, Give Year or Dates:	? ]No	lf	Yes, sp	ecify Cubar	Specify:	erto Ric	can, etc.)		Black, V	Vhite, 6	
2-003e	2 hou	ed	15. Decedent's E	ducation	•	16a. Deced	ent's Us	ual Occupa	tion			16b. K	ind of Busine		
ر 12	nin 72 na "na Media	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4or	· F · \	(Give i	kind of w	ork done d use retired)	uring most of i	working		100.10	ind of busine	333/1110	lustry
7	filed within Hygiene. other than	ĕ	Elementary/Secondary (0-12)	5+	5+)	]	HOME	MAKER				C	WNED I	MOE	Ε
2		Be C	17. Father's Name (First, Middle, Last	)					18. Mother's I	Name (F	First, Middle	, Maiden	Sumame)		
yland		To	VICTOR PINTO						MARY R	EGO					
Mar	O1 (0 w est		19a. Informant's Name/Relationship						nd Number or						
	es t and 2 of Heelth litem 27 i		ILA DAVE/DAUGHTE	.R	201 5				LE RD.		-				
saitimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci		9 C	Place of Disposementery, crem	atory or	other place		Date 09 <b>–</b> 0			EL, M		wn, State
Dail	permit. Pages Department of h Important: If ite any injury or of once.		21. Signature of Fureral Service Lice	with the second					s of Facility SPRIN				HOME, MD	, IN	C.
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death	h. Do not ente	or the mo	de of dying	, such as card	diac or re	espiratory a	rrest,			Approximate
_	Physician		Immediate Cause (Final disease or condition			EROTIC	COR	ONARY	VESSE	L DI	ISEASE			,	Interval Between Onset and Death YEARS
	/Medical		resulting in death)	Due to (or as										+	
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	₽ ≒	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	uence of):									
	ecute and -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or c											
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X	death certific e attending pl d for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregna	incy							23d. Date of	dolivo	2,
X D D	death a atter	Physician/M	in the past 12 months?	1☐Live birth 4☐Pregnant a			Ectopic potential Control of the Con	regnancy pecify)					Month		Day Year
	t the by the ache	hys	9 Unknown	9□ Unknown	171										
ecords, P	wrequires that the de been signed by the s should be detached	by	Part II. Other significant conditions of HYPERTENSION	contributing to death	but not resu	ulting in the un	derlying	cause give	n in Part I.						a cause of death?
Ö	law req as beer 2 shou	lete	HYPERLIPIDEM	A						_	24a. Was				
r	The ate ha	Completed								-	autor	osy irmed?	prior	to com	sy findings available in pletion of cause of 2 No
VII	Physiclan: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?						26. Place of D	Death (C	Check only o	ле)			
=	hys his il dii	7	1 ☐ Yes 2 No			ER/Outpatient			4   Nursing				6 □Other (S	pecify,	)
000	ding P th. After funera	Certification:	27. Manner of Death  1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	м	28c. Injury Work' 1 □ Y	at ? es 2 □ No	280	d. Describe	how injur	y occurred		
DIVISION	r Attender death rector:	fica	3 Suicide 6 Could not b	OB Class of In	njury - At ho	ome, farm, stre				28f.	. Location (	Street an	d Number or	Rural	Route Number,
5	itel or rel Dire		4   Hornicide								City or To	wn, State	)		
	To the Hospitel or Attending P within 24 hours efter death. To the Funerel Director: After t completely filled in by the funera	Medical	29a. Certifier 11 Certifying PI (Check only one) 2Medicel Exer	nysicien: To the best miner: On the basis of and manners	of examinat	wledge, death tion and/or inv	occurred estigatio	at the time n, in my opi	e, date and pla inion, death o	ace, and courred	d due to the at the time,	cause(s) date and	and manner place, and	as sta due to	ited. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	P 1			1 29	c. License	number			29d. Dat	e signed (M	onth, E	Pay, Year)
			I Laniel &	LAN	och	sull			D45533			12/	08/04		
1	1		30. Name and address of person who												
	)		DANIEL E. SNOW,			IVERSI	TY E	LVD.	W #400	WHI	EATON,	MD	20902		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 9 2004	32. Regist	trar's Signal	ture L	0	,							

State of Maryland / Department of Health and Mental Hygiene) 38953 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 28, **Physician** Ernst W. Braun November 2004 5:00 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 422 Scarsdale Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 7, 1934 Birthplece (State or Foreign Country)
 Germany 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 216-26-7660 1 M 2 □ F 69 Director Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examples into the modified at 1√2Yes 2 □ No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 422 Scardale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after i Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itel any injury or other traumatic event, Ite Medical Exam at once. Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) meat cutter grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernst K. Braun Emma Hetsel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marianne Braun/spouse 422 Scarsdale Road Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 F 4 Donation 5 Oner (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Enter the diseast, or communications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit the attending physicien and Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 4 Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate has page 2 autopsy performed?

1 Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. escribe how injury occurred Certification: Alter t 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stategt. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Moham DO57061 auro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4920-CAMPBELLBEND, Baltimore, MD 21236 RANA, MD MOHAMMAD. M. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - State of Mar State of Mar Registrar	yland / Depa <i>Cei</i>	artment of Health and tificate of Death	Mental Hygie		38954
	Di		Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		HENRY BEZNE	P		111-2	6 - 04	1.50.PM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deat		4c. County of Dear	
			Fairland Nursing Home 5. Social Security Number 6. Sex 7. Age (	for any for all high to A	Silver Spring		Montgor	
	Funeral Director		W	In yrs. last birthday)  3 Yrs.	Months Days Hours Min		aari Co	thplace (State or Foreign unk
			Usual Residence of Decedent			Apr 30,	1931	
	death with the Maryland rms 23a or 28a-f show			0c. City, Town or Lo				10d. Inside City Limits
	e Ma	Director	MD Montgomery	S:	ilver Spring			1 ☐ Yes 2√ No
	or 26	Olre	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry?
	s 23a	rai	2101 Fairland Road		20904		USA	
	er de Items	Funerai	11. Marital Status Unk 12. Was Decedent Ev		Nas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
2000	irs aft	by F	1  Never Married 2  Married 1  Yes 2  No If Yes, Give 3  Widowed 4  Divorced Year or Dates:	unk	1 ☐ Yes 2🌠 No Specify:		Specify:	White
ž	be filed within 72 hours after death with the Marylar dia Hygiene. All Hygiene. All than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, It a Madical Examiner must be indiffed at		15. Decedent's Education		dent's Usual Occupation	unk 16b	b. Kind of Business/	
<u>'</u>	thin 7 e. an "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  Unk  College (1-4or 5+)	life. I	kind of work done during most of wo DO NOT use retired)	rking		
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	ital H id oth	Be	17. Father's Name (First, Middle, Last)		unk 18. Mother's Na	me (First, Middle, Maid	ten Sumame)	unk
2	ges 1 and 2 should be it of Health and Mental If item 27 is marked o or other traumatic eve	2	100 left and the New of Relationship (Time Relationship)	405 14-75				
<u> </u>	ロボンド		19a Informant's Name/Relationship (Type, Print) Fairland Nursing Home		g Address (Street and Number or Ri			
e,	1 and Health em 27 sther ti		20a. Method of Disposition	20b. Place of Dispo	1 Fairland Road S		Lng, MD	20904 Town State
Ē	permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natory or other place)	250	. Location Oity of	Town, State
altil	artme ortan injur		Constitute of Euparal Service Licenses	22	. Name and Address of Facility			
ñ	Department on the concession o		Ronald S. Mad, Direct		Name and Address of Facility tate Anatomy Boa		Baltimore	Street
Ħ			23. Part 1. Enter the disease, or complications that caused the	e death. Do not ente	Saltimore, MD 21 or the mode of dying, such as cardia	201 c or respiratory arrest,		Approximate
	Physician		) shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		18 ATORINA	2 1 1 - 5 -		Interval Between Onset and Death
	/Medical		resulting in death)  a. Due to (or as a death)	consequence of):	1 RATORY AK	REST		
	Examiner		Sequentially list conditions.	15				
	p ÷	iner	if any, leading to immediate Due to (or as a cause. Enter Underlying	consequence of):				
	and -trans	Examiner	that initiated events c.	STAGE	E DEMEN	LTIA		
8/PU,	icate be executed physician and s the burial-transit		bue to (or as a c	onsequence or).				
200	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	dlcal	d					
XOX	sician: The law requires that the death certific certificate has been signed by the attending p rector, page 2 should be detached for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of				23d. Date of deli	iverv
ă	death e atte d for	cia	in the past 12 months?  1 □ Yes 2 □ No   1 □ Yes 2 □ No		Ectopic pregnancy  Other (specify)		Month	Day Year
j.	t the by the	Physi	9 ☐ Unknown 9 ☐ Unknown					
ν) T	as tha	by P	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ğ	en sig					1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
ပ္ပ	law re as be 2 sh	ompleted				24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
ľ	The I	Соп				performed	? death?	2 □ No
VITAI	cian: ertific ector,	Be	25. Was case referred to medical examiner?			ath (Check only one)		
5	Physi this c	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Other: 4 Nursing H	lome 5 Residence		cify)
ב	ling F	lo	27. Manner of Death 1. ✓ Natural 5 ☐ Pending (Month, Day Y	'ear) 28b. Time of Injury	Work?	28d. Describe how in	njury occurred	
UNISION	death death ctor: / the	cat	2 Accident investigation 3 Suicide 6 Could not be	- At home, farm, stre	M 1 Yes 2 No	28f. Location (Street	and Number or Dr	und Courte Number
⋛	after Dire	Certification;	4 Homicide determined 288. Place of Injury building, etc. (	Specify)	set, ractory, office	City or Town, St		irai modie ivamber,
	spita nours neral		29a. Certifier 1 Certifying Physician: To the best of	ny knowledge, death	occurred at the time, date and place	and due to the cause	e(s) and manner as	stated.
	To the Hospital or Attending Physician: which 24 hours after death and the fundation of the Fundation for the fundation of the fundation in the fundation of the fundation in the fundation of the fundation in the fundation in the fundation of the fundation in th	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner state	tamination and/or inv	restigation, in my opinion, death occu	irred at the time, date	and place, and due	to the cause(s)
	To t Withi To tl	Ž	29b. Signature and title of certifier		29c. License number 20061096		Date signed (Month	
			· Gusha Mo		10061076	12	2/01/0	ウラ
			30. Name and address of person who completed cause of dea					
			USHA GOLLAPALLI &	Signature	CONDAVENUE	SILVER	SPRING	MD-20910
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 8 2004	Signature Accept	,			
	3.0.		UEU U 8 2004 Bayers	- Approved	s-			

		•	For State Registrar	State of Mar		artment of rtificate o		Mental Hy	rgiene 200	38955
	Physici	an	1. Decedent's Name (First, Middle, La Evelyn Mar	,				2. Date of De Month	eath	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give the Action of	re street and number)	RTAL		n, or Location of De	ath	4c. County of De	eath
	Funeral Director		220-03-7981	Sex 7. Age (I	In yrs. last birthday) 84 Yrs.	If Under 1 Ye Months Day				Birthplace (State or Foreign Country) MD
	h the Maryland r 28e-f show notified at	or	Usual Residence of Decedent  10a. State 10b. County  MD Anne Ar		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	₩ 2 M	I Direct	10e. Street and Number 210 South Broadv	iew Blvd.		10f. Zip Code	21061		10g. Citizen of What	
	or Ite	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C 1 ☐ Yes 2 🛣 N	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		пелсал Indian, hite, etc. white
ည်	"net	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	(Give	dent's Usual Occ kind of work do DO NOT use ret Homemake	ne during most of v ired)	vorking	16b. Kind of Busines	,
land 2	be filed ital Hygi id other event, I	o Be Co	5 17. Father's Name (First, Middle, Last Edgar R. Fog.			- I om omake	18. Mother's N	lame (First, Middle	Home Consider Sumame)	wiiet
	od 2 shi lth and 27 is m treum		19a Informant's Name/Relationship (						er, City or Town, State MD 21054	, Zip Code)
imore	0 0		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci	Removal from State	20b. Place of Dispo cemetery, crei Glen Have	natory or other p	olace)	Date 13/04	20c. Location - City of Glen Burn	
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Lice	M013			Ave. SW,	Singleton Glen Bur	Funeral H	ome PA 061
	Medical /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a co	EMYE onsequence of):		yying, such as card	lac or respiratory a	irrest,	Approximate Interval Between Onset and Death
x 68760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dlcal	resulting in death) Last  IF FEMALE:	Due to (or as a co						
.O. Box	that the death or ed by the atten detached for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnal Other (specify)			23d. Date of d Month	elivery Day Year
Records, P	w requires tha been signed should be dei		Part II. Other significant conditions (	ontributing to death but n	ot resulting in the u	nderlying cause	given in Part I.		obacco use contribute Yes 2□No 3□I	to the cause of death?  Probably 4 Monknown
l Rec	The law ate has b page 2 st	Completed						24a. Was autor perfo 1 Yes	rmed / death	autopsy findings available o completion of cause of es 2 No
	ding Phys h. After this funeral dii	tlon: To Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 □ Pending 2 □ Accident investigatio	Hospital: 1 Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. In W	Other: 4 \( \text{Nursing}		one) dence 6 □Other (Sp how injury occurred	ecify)
=	spitel or Attending ours after death. erel Director: After filled in by the fune	Certification:	3 Suicide 6 Could not be determined	e One Place of Indiana	- At home, farm, str Specify)			28f. Location (: City or Tox	Street and Number or I wn, State)	Route Number,
	To the Hospitel or Atten within 24 hours after deal To the Funerel Director: completely filled in by the	Medical C	one)	ysician: To the best of miner: On the basis of example and manner stated	amination and/or in	occurred at the	time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	is stated. ue to the cause(s)
	To to to to to to to to to to to to to to	Σ	29b. Signature and title of certifier	10	MI		nse number		29d. Date signed (Mor	
	(//		CNASTO B		situl D	Print)	Glace P	suxue	MB 211	ER 6 2009-
97, 	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 9 2004	32. Registrar's		Sporks	/			

			1- For Amend Item 23a State of Mandand 1 Department of Health and Me Registrar Certificate of Death	ental Hygien	2004 38956
	Physici /Medic Examir	cal		2. Date of Death Month December	ay Year 3. Time of Death 1St 2004 7:46P M
	Funeral Director	lei	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1	8. Date of Birth (Month, Day, Year Sept. 13,	N/A  9. Birthplace (State or Foreign Country)
ī	the Maryland 28a-f show	ار ا	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland N/A Baltimore		10d. Inside City Limits 11 Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 420 Arsan Avenue 10f. Zip Code 21225	10g. C	itizen of What Country?
9036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperfinent of Health and Mental Hygiene. Importants if Item 27 Ie marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, if a Mudical Examiner must be notified at once.	by	11. Marital Status  1	ify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 h giene. er than "natu itte Modica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  O  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Never worked	g 16b. I	Kind of Business/Industry  N/A
Maryland	should be file nd Mental Hy, marked othe imatic event,	To Be C		ryn Wistl:	ing
	es 1 and 2 st of Health and of Health and I Item 27 le r r othar traun		20a. Method of Disposition Da	timore, Ma	or Town, State, Zip Code)  Aryland 21225  .ocation - City or Town, State
Baltimore,	pernit. Page Depirtment c Important: If any injury or once.		'4 Donation 5 Other (Specify) Cedar Hill Cemetery 12/4/	ce Funera	timore, Maryland  1 Service, P.A.
8760,	/Medical Examiner	Ilcal Examiner	23a. Pank. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Cerebral Palsy  Due to (or as a consequence of):  d.	respiratory arrest,	Approximate Interval Between Onset and Death
.O. Box 6	ath certific trending p	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 4  Pregnant at time of death 9  Unknown  23c. If yes, outcome of pregnancy 1  Clive birth 2 Fetal death 4  Pregnant at time of death 9  Unknown		23d. Date of delivery Month Day Year
Records, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 Unknown
al Reco	ician: The law r certificate has be ector, page 2 sh	Completed		24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
ion of Vital	ding Phye	atlon; To Be	25. Was case referred to medical examiner?    Yes   2 No	,,	
Division	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the	Certification;	4 ☐ Homiciae building, etc. (Specify)	City or Town, State	
j	To the Hosp within 24 hou To the Fune completely fil	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date and	d place, and due to the cause(s)
	Mill To	~	29b. Signature and title of certifier  Residut RESOOI	29d. Da	te signed (Month, Day, Year)
		200	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1 amader Mira 3001 S. Hanover St	- Balt	imor MOZIZZS
	Sta Regiștr		31. Date filed (Month, Day, Year)  32. Registrar's Signature  DEC 0 9 2004		

	Physic /Medi		Bernice	Beatri	.ce	Col	.e	Month Decemb	er 5 2	Year 004 7:00a.
Ì	Exami		4a. Facility Name (If not institution, g	ive street and number)			Location of Death		4c. County	of Death
			Milford Manor			Pikesv			Balt	imore
	Funeral Director		214-24-7041	. Sex 1	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 08	l 23	Birthplace (State or Foreig Country)     MD
	and *		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Loc	cation				1404 1 2 2 2 2 2 2
	sho	7								10d. Inside City Limits
	he N	Director	MD NA		Baltimo		· ·			1 ∑ Yes 2 □ No
	with a or 3	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	s 23	Funeral	4800 Yellowwoo	od Ave Apt	#616		1209		U.S	5.A.
	ltem	E		Armed Forces?	in U.S. 13. V	Vas Decedent of Hi Yes, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race Black	- American Indian, k, White, etc.
36	rs af	by	1 Married 2 Married 3 Widowed 4 Divorced	I ☐ Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify.	:
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show aumatic event, I's Medical Exterigine must be notified at	ed	15. Decedent's		16a. Deced	ent's Usual Occupa	ition		16b. Kind of Bu	Black
5	in 72	Completed	(Specify only highest	grade completed)	(Give I	kind of work done d OO NOT use retired;	luring most of workir	ng .	160. King of Bu	siness/industry
27	within piene. r than "	mo	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+)		mestic N			Dν	civate
B	filed Hygid other	Be C	17. Father's Name (First, Middle, La				18. Mother's Name	(First, Middle,		
a	ould be the Mental I arked o	To B	Raymond Cole				Mary Do	rsev		
ary	s 1 and 2 should   f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street a	nd Number or Rura		r, City or Town,	State, Zip Code)
	5 <b>5</b> 5		Doris Coates-I	aughter			ood Ave			21209
ē,	es 1 ar of Hea of Hea of Heam r other		20a. Method of Disposition	20	b. Place of Dispos	sition (Name of atory or other place	Di			City or Town, State
E	Pages nent of int: If it		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec		New Cati		12/10	104 F	Raltimo	ore, Md
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lic		22.	Name and Address	s of Facility	70-1	Jarcinc	ole, na
m	Per la pe		- Maxino	2 X		arch F/I	H West ash Ave,	Ral+i	more.	Md 21215
			28a. Part1. Enter the disease, or co shock, or heart failure. List on	molications that caused the	death. Do not ente	r the mode of dying	, such as cardiac or	respiratory arr	est,	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. End-Stage Due to (or as a cor	nsequence of):	Sons				Interval Between Onset and Death
Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a con						
o.	o = ®	nysician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 moonts? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 ☐8	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
Vital Records, P	requires that the een signed by t hould be detach	d by Phy	Part II. Other significant conditions	contributing to death but not	resulting in the und	derlying cause giver	n in Part I.			oute to the cause of death?
Ö	w require been si should b	Completed				****				
æ	e la has je 2	m d						24a. Was ar autops perforn	y pri	ere autopsy findings available for to completion of cause of eath?
<u></u>				T						Yes 2 No
⋚	ysicien: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death			
ō	Phys this ral di	2	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA	4 Whursing Hom			
Division	Attending Physicien: r death. sctor: After this certific by the funeral director,	Certification:	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	(Month, Day Yea	r) Injury		es 2 No	d. Describe no	w injury occurred	
Ω	urs after or Al		4 Homicide determine	building, etc. (Sp	ecify)			City or Town	, State)	r or Rural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	ledicai	one)	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death on nination and/or inve	occurred at the time estigation, in my opin	, date and place, an nion, death occurred	nd due to the ca d at the time, da	use(s) and mani ate and place, an	ner as stated. Indicate to the cause(s)
	To To	Σ	29b. Signature and title of certifier			29c. License			1	(Month, Day, Year)
)			> nollajafah	KNO			D 57 46.	5	12/6	104
	10		30. Name and address of person who N'S Rappalse, MC		Item 23a) (Type, Pi Street, Suit	rint) e 200, Re	cisterstown	MD 21	136	
	Cto		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignatura					

Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

		1	For State Registrar		partment of Health and leartificate of Death	Reg. 1	ZHHU KMYSK
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physicia /Medic		William Madison Chi	.ldress		2000	2004 4:45 PM
	Examin	<b>3</b> 1	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat Lutherville	h '	tc. County of Death Baltimore
			15 Ridgefield Rd. 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs	8. Date of Birth	
	Funeral Director		720–18 <b>–</b> 0053	M 2□F 85 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea September 4	4,1919 Kentucky
	P .		Usual Residence of Decedent	10c. City, Town or	Location		10d. Inside City Limits
	anylar show	2	10a. State 10b. County  Maryland Baltimore				1 ☐ Yes 2 🌠 No
	the M	ecto	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?
	3a or	٥	15 Ridgefield Rd.		21093	Uni	ited States
	tiled within 72 hours after death with the Maryland Hygiene. other than "natural", or terma 23a or 28a-f show ent, tra Medical Examiner must to multified at	by Funeral Director		12. Was Decedent Ever in U.S. 1 Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	after or the	Fu	1 Never Married 2 Married	1 XX Yes 2 □ No tr Yes, Give	1 ☐ Yes 2XXNo Specify:		Specify:
Ö	hours tural',	q p	3 X Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates: WW 11	cedent's Usual Occupation	16b.	white Kind of Business/Industry
<u>.</u>	in 72 n°na	plete	(Specify only highest grade	(Gallege (1, 4or 5 t))	ve kind of work done during most of wo b. DO NOT use retired)		
212	d with giene. or the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Manag	ger Customer Relat		partment Store
g	al Hyg	Se l	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid ce Mammen	en Surname)
yla	12 should be filed within and Mental Hygiene. 7 is marked other then "reumatic event, the Men	To	Reuben Madison Chi.		ailing Address (Street and Number or R		v or Town State Zin Code
Maryland 21215-0036	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Ty) Diane McCarter/dau			icott City,	
	Healt Healt tem 2		20a. Method of Disposition	20b. Place of Dis	sposition (Name of rematory or other place)	Date 20c.	Location - City or Town, State
ПO	Pages nent of I ant: If Its ary or o		1 XBurial 2 ☐ Cremation 3 ☐ R  1 4 ☐ Donation 5 ☐ Other (Specify)		aptist Church Dec.	10,2004 T	imonium, Maryland
Baltimore,	コモモラ		21. Signature of Funeral Service License		22. Name and Address of Faculity Mitchell - Wiede		al Home, Inc.
m	Deparent Import any ir		John O. Mitc	Kell	6500 York Rd.	Baltimor	e, MD 21212
H.				cations that caused the death. Do not ne cause on each line.	enter the mode of dying, such as cardia	ic or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	Metastatica	evanoma of	1 neci	< 2 years
	/Medical Examiner		1	Due to (or as a consequence of):	V		
		er	Sequentially list conditions, I my Lading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	cuted Id ransit	듣		Due to (or as a consequence or).			
	0 2 7	E	that initiated events	:			
Ô	e ex ian	Examine	Cause (Disease or injury				
8760,	ate be executed oblysician and the burial-transit		that initiated events	:			
x 68760,	th by		Cause (Disease or injury that initiated events resulting in death) Last	:			23d. Date of delivery
Box 68760,	th by		Lause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
.O. Box 6	th by		IF FEMALE: 23b. Was decedent pregnant	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy 1			Month Day Year
P.O. Box 6	th by	Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy  1	5 Other (specify)		Month Day Year
P.O. Box 6	th by	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy  1	5 Other (specify)	23e. Did tobacc 1 □ Yes	Month Day Year
P.O. Box 6	aw requires that the death certificate is been signed by the attending phy 2 should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy  1	5 Other (specify)	1 ☐ Yes 24a. Was an autopsy	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of
P.O. Box 6	The law requires that the death certificate ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy  1	5 ☐ Other (specify)e underlying cause given in Part I.	1 Tes  24a. Was an autopsy performed 1 Yes 2	Month Day Year  co use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?
P.O. Box 6	The law requires that the death certificate ate has been signed by the attending phypage 2 should be detached for use as the	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions con CAD  25. Was case referred to medical examiner?	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy 1	e underlying cause given in Part I.  26. Place of De	1 Yes  24a. Was an autopsy performed 1 Yes 2 Aaath (Check only one)	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
of Vital Records, P.O. Box 6	Physician: The law requires that the death certificate this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 27. Manner of Death	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy 1	e underlying cause given in Part I.  26. Place of Detiint 3 DOA	1 Tes  24a. Was an autopsy performed 1 Yes 2	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Cother (Specify)
of Vital Records, P.O. Box 6	ing Physician: The law requires that the death certificate in this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  attributing to death but not resulting in th	e underlying cause given in Part I.  26. Place of Detection 3 DOA Other: 4 Nursing of 28c. Injury at	1 Yes  24a. Was an autopsy performed 1 Yes 2 A eath (Check only one)  Home 5 Residence	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Cother (Specify)
of Vital Records, P.O. Box 6	ing Physician: The law requires that the death certificate in this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions condi	Due to (or as a consequence of):  d.  3c. If yes, outcome of pregnancy 1	e underlying cause given in Part I.  26. Place of De  tient 3 DOA Other 4 Nursing e of Vork? M 1 Yes 2 No	1 Yes  24a. Was an autopsy performed 1 Yes 2 Seath (Check only one)  Home 5 Residence 28d. Describe how in	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  Injury occurred
P.O. Box 6	or Attending Physician: The law requires that the death certificate iffer death.  Sirector: After this certificate has been signed by the attending phy, in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending investigation 3   Suicide 6   Could not be determined	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence)   Due to (or as a consequence):   Due to (or as a con	e underlying cause given in Part I.  26. Place of Determine tient 3 DOA Other: 4 Nursing e of y Mork?  M 1 Yes 2 No. street, factory, office	1 ☐ Yes  24a. Was an autopsy performed 1 ☐ Yes 2 ☑ aath (Check only one)  Home 5 ☑ Residence 28d. Describe how in 28d. Location (Stree City or Town, S	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No  6 Other (Specify)  Injury occurred  and Number or Rural Route Number, late)
of Vital Records, P.O. Box 6	or Attending Physician: The law requires that the death certificate iffer death.  Sirector: After this certificate has been signed by the attending phy, in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence):	e underlying cause given in Part I.  26. Place of Detection and Doal of their street, factory, office  26. Place of Detection and Doal of their street, factory, office	24a. Was an autopsy performed 1 yes 2 state (Check only one) Home 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, Stree, and due to the caustern autopsy per street	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  niury occurred  t and Number or Rural Route Number, late)  a(s) and manner as stated.
of Vital Records, P.O. Box 6	or Attending Physician: The law requires that the death certificate iffer death.  Sirector: After this certificate has been signed by the attending phy, in by the funeral director, page 2 should be detached for use as the	To Be Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions condi	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence):	e underlying cause given in Part I.  26. Place of Detection and Doal of their street, factory, office  26. Place of Detection and Doal of their street, factory, office	1 Yes  24a. Was an autopsy performed 1 Yes 2 Seath (Check only one)  Home 5 Residence 28d. Describe how in 28f. Location (Stree City or Town, See, and due to the causturred at the time, date	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  niury occurred  t and Number or Rural Route Number, late)  a(s) and manner as stated.
of Vital Records, P.O. Box 6	ttending Physician: The law requires that the death certificate death. stor: After this certificate has been signed by the attending phy, the funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence):	e underlying cause given in Part I.  26. Place of De  ttient 3 DOA Other: 4 Nursing e of y M 28c. Injury at Work? 1 Yes 2 No street, factory, office  eath occurred at the time, date and place or investigation, in my opinion, death occurred.	1 ☐ Yes  24a. Was an autopsy performed 1 ☐ Yes 2 ☑ eath (Check only one)  Home 5 ☑ Residence 28d. Describe how in 28f. Location (Stree City or Town, Street at the time, date 29d.	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No  6 Other (Specify)  niury occurred  and Number or Rural Route Number, late)  e(s) and manner as stated. and place, and due to the cause(s)
of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions conditions are referred to medical examiner? 1   Yes 2   No 9   No 9   Very referred to medical examiner? 1   Yes 2   No 9   No	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence):	e underlying cause given in Part I.  26. Place of De titient 3 DOA Other: 4 Nursing e of Work? M 1 Yes 2 No street, factory, office  eath occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation, in my opinion, death occurred at the time, date and place investigation.	1 Yes  24a. Was an autopsy performed 1 Yes 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  niury occurred  and Number or Rural Route Number, late)  (s) and manner as stated, and place, and due to the cause(s)  Date signed (Month, Day, Year)
of Vital Records, P.O. Box 6	or Attending Physician: The law requires that the death certificate iffer death.  Sirector: After this certificate has been signed by the attending phy, in by the funeral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions conditions are referred to medical examiner? 1   Yes 2   No 9   No 9   Very referred to medical examiner? 1   Yes 2   No 9   No	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence):	e underlying cause given in Part I.  26. Place of Determination of Determi	1 Yes  24a. Was an autopsy performed 1 Yes 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Month Day Year  to use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  niury occurred  and Number or Rural Route Number, late)  (s) and manner as stated, and place, and due to the cause(s)  Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	aryland		artmen rtificat			and M	-	giene Reg. No.	ו חחג	38959
	Physici /Medic		1. Decedent's Name (First, Middle, La Flenall	st)		Ca	rter	3rd	E		2. Date of Dea Decemb	er Day	, 2004r	3. Time of Death 1937 p M
	Examir		4a. Facility Name (If not institution, giv Harbor Hospital	e street and number) Center				Town, or	Location o	of Death		4c. (	NA	th
	Funeral Director		5. Social Security Number 6. S 214-11-1588	NOTAL OF F	ge (In yrs. las 18	t birthday) Yrs.	If Under Months		If Under :	24 Hrs. Min.	8. Date of Birt (Month, Da 12-2	h v. Year) <del>-</del> 85	9. Bir Co	thplace (State or Foreign buntry) Md.
	how		10a. State 10b. County		10c. City, 1	Town or Lo	cation							10d. Inside City Limits
	Ba-f s	Director	Md. NA			Ba	ltimo							¶Yes 2 No
	with ti	급	10e. Street and Number 1315 Slater Rd.				10f. Zip	Code 21225	:			10g. Citiz	en of What Co	ountry?
	ns 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. 1				gin? (Spe	acity Yes or No-	. 1	USA 4. Race - Ame	arican Indian
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, I'le Medical Exacilisat must be notified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 Y  If Yes, Give  Year or Dates:			fYes, spec 1 ☐ Yes		Specify:	, Puèrto	ecify Yes or No- Rican, etc.)		Black, Whit	
5	72 hc natur	etec	15. Decedent's E (Specify only highest gra		1	16a. Deced (Give	tent's Usua kind of wor DO NOT us	al Occupa rk done d	ition furing most	of worki	ina	16b. Kin	d of Business	/Industry
Maryland 21215-0036	filed within Hygiene. Ither then '	Completed	Elementary/Secondary (0-12)  11th grade  17. Father's Name (First, Middle, Last,	College (1-4or	5+)		udent					N.		
yland	2 should be fi and Mental F is marked ot is marked ot	To Be	Flenall		Carte				Sł	nerr:			Wigg	
	Health and tam tam 27 is m		19a. Informant's Name/Relationship ( Sherrie Wiggins	Type, Print) Mother		19b. Mailir 1	.315 S	(Street a	nd Numbe er Rd.	rorRuma ., Ba	A Route Number	r, City or e, Mo	Town, State, 212	
Baltimore,	Pages 1 nent of H ant: if itan ury or oth		20a. Method of Disposition  1       Burial 2 □ Cremation 3 □      4 □ Donation 5 □ Other (Specif.)		cem	e of Dispo etery, cren ng Me	natory or o	ther place	-	□ )-8=2	)ate )4		ation - City or Idallst	Town, State
Balt	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licer	Walter	2		. Name an						ore, Mo	
Е			231. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	the death.	Do not ent	er the mod	e of dying	, such as	cardiac o				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Multip	15 Gu	N)HIT	with	nds						Onset and Death
	/Medical Examiner		Typoding in death)	Due to (or as	a consequen	nce of):								
l.	9;	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequen	nce of):								
	ecuted and -transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	ate be executed hysician and the burial-transit	ai E		Due to (or as	a consequen	109 01):								
687	iate the	edicai		d										
О. Вох	at the death certific by the attending p stached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic pro Other (spe					23	d. Date of del Month	ivery Day Year
S, P	es tha gned se de	by Pt	Part II. Other significant conditions of	ontributing to death b	ut not resultir	ng in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ord	w requir been si should I	eted									1 🗆 Y			obably 4 Unknown
Vital Record	The larate has	Completed									24a. Was a autop: perfor Yes	sy	24b. Were au prior to death?	itopsy findings available completion of cause of 2 No
Vit.	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1    Yes 2   No	Hospital: 1 ☐ Inpatie	at METER	VOutpatien	- 2000	A Othe	-		(Check only or			
	ig Phy ter this neral c	-	27. Manner of Death	28a. Date of Inju (Month, Da	iry 28	3b. Time of		Bc. Injury Work	4 🗀 1901		ne 5 Resid			cify)
Sior	Attending ir death. actor: After by the fune	atlo	1 □Natural 5 □ Pending 2 □ Accident investigation	121104		1105	PM	1 🗆 Y	es 200	10	SUBJEC	TW	as sitet	
Division	or in Dir	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	c. (Specify)	o, farm, stre	eet, factory	, office		2	28f. Location (S City or Tow	treet and	Number or Ru	iral Route Number, K Tenth STVEST
	the Rospital hin 24 hours a the Funaral upletely filled	ledical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Medicel Exem	nysician: To the best niner: On the basis o and manner st	f examination	dge, death and/or inv	occurred a restigation,	at the time in my op	e, date and inion, death	d place, a	and due to the c	31150/c) 3	nd mannor as	stated. to the cause(s)
)	To To Com	W	29b. Signature and title of certifier	M. /2	1		00	License ME			I	Decem	signed (Month	2004
1	}		30. Name and address of person tho	completed cause of d	leath (Item 23	3a) (Type, I	Print)111	Pen	n Str	eet,	, Baltir	nore	MD 212	01
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	9	1							
	negistr	u)	DEC 0 9 200	14 Stepa	مهمر	D	200	Ms	/					

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygieney

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Pasadena

Middle RIver, MD. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Approximate Interval Between Onset and Death Maus 23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2XNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 stesidence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 29c. License number 216 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) 32. Registrar's Signature ORIGINAL

2. Date of Death Month

8,

2004

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

USA

Anne Arundel

Dec.

Year

2:10

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

NC.

14. Race - American Indian,

White

Telephone Company

Black. White, etc.

Registrar

State

1 - For State Registrar

759

**Physician** 

/Medical

**Examiner** 

**Funeral** 

1. Decedent's Name (First, Middle, Last)

D.

216th St.

4a. Facility Name (If not institution, give street and number)

Drum

1 M 2 F

Gaynell

5. Social Security Number

DHMH 17 Rev 1/2001

M

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

		_	For State Registrar		Maryland / Dep Ce	ertificate of			Reg. No2	04	38961
	Physicia	an	Decedent's Name (First, Middle	Last)				2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic	al	Barbara	Inez		linger			er 8, 2		9:30 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution		r)	4b. City, Town, o		Death		ty of Death	
	Funeral		7484 Rabon Avenu 5. Social Security Number		Age (In yrs. last birthda)	Dunc ) If Under 1 Year	Ialk If Under 24	4 Hrs. 8. Date of Bi	eth.	1timor	
Н	Funeral Director		216-42-0028	1 ☐ M 2 【X F	60 Yrs.	Months Days		Min. (Month, Di May 9,	1944	Cour	place (State or Foreign htry) D
	P _		Usual Residence of Decedent					1 2 7			
	anyla shov	-	10a. State 10b. County		10c. City, Town or i					1	0d. Inside City Limits
	88a-1	Director	MD. Balt	imore	Dund						1 ☐ Yes 2 No
	with a or	급	7484 Rabon Aven	110		10f. Zip Code 2122	2		10g. Citizen o	T What Cour	ntry?
	ns 23	Funerai	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13			n? (Specify Yes or No		ace - Americ	an Indian,
٥	or Iter	Fun	1 Never Married 2 Marri		s? ¶No			n? (Specify Yes or No Puerto Rican, etc.)	В	lack, White,	etc.
5-0036	ral', c	l by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates	s:	1 ☐ Yes 2 No	Specify:		Spec	ity: Wh	ite
<u>.</u>	72 h "natu	Completed	15. Decedent (Specify only highes	s Education t grade completed)	(Giv	edent's Usual Occup e kind of work done	during most of	of working	16b. Kind of	Business/Inc	dustry
121	within ane. than	du	Elementary/Secondary (0-12)	College (1-4o	r 5+)	DO NOT use retire	a)		Orm	Home	
2	filed within 72 hours after death with the Maryland Hygiene. other than. ent, the Mydical Examinar must be notified at		10 years 17. Father's Name (First, Middle, I	.ast)	но	usewife	18. Mother's	s Name (First, Middle			
<u>a</u>	ed ta	To Be	Charles Church				Ver	a Bethel			
Maryland 2121	s 1 and 2 should of Health and Men itsm 27 is marked other traumatic		19a. Informant's Name/Relationsh					or Rural Route Numb			Code)
	t and 2 Health sm 27 I		Bonita Church	sist			venue,	Dundalk,M	id. 2122	22	
altimore,			20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 ☐Removal from Stat	(B)	ematory`or other pla		ecember	20c. Location	n - City or To	own, State
ᆵ	t. Pag tmen tent:		*4 □ Donation 5 □ Other (Sp	ecify)	Bayview	Crematory	,	1, 2004			ity,MD.
Ba	permit. Page Department Important: If any injury o		21. Signature of Funeral Service of the Charles	C. Cor	nel lu	7110 Soll	ers Po	l Home Of int Road,	Dundla	k,P.A.	21222
II.	20.		23a. Part1. Enter the disease of shock, or heart failure. List	complications that caus only one cause on each	ed the death. Denot e line.	nter the mode of dyi	ng, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
-	Pnysician	å n	Immediate Cause (Final disease or condition resulting in death)	-a Lur	a Cance	25	_,_			4	Onser and Death
R	/Medical Examiner		roodking in dodding	Due to (or a	as a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequence of):					-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Citients or injury) that initiated events	c						- 4	
o,	an an irial-tr		resulting in death) Last		as a consequence of):						
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai		d							
9	eath certific attending pl	/Mec	IF FEMALE:	22a If upa cutoon	a of areas						7
Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc	у			ate of delive Jonth	Day Year
Р. О.	that the de led by the a detached	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown		Other (specify)					
	es that igned by be deta	by Pr	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco use co	ntribute to th	ne cause of death?
Vital Records,	w require: been sig should b							1□	Yes 2□No	3 Prob	ably 4 Unknown
900	aw re	plet						24a. Was		. Were auto	psy findings available mpletion of cause of
ž		Completed						auto	ormed? 2 No	death?	2 No
/ita	ysician: The is certificate director, pag	Be (	25. Was case referred to medical examiner?					of Death (Check only			
of \	Physi this c	6	1 Yes 2 No		tient 2 ER/Outpati	SIL SU DOA		sing Home 5 Res			y)
Division of	ding Ph h. After th funeral	ion	27. Manner of Death  1 Natural 5 Pending 2 Accident Investig		njury 28b. Time Day Year) Injury	Wo	rk? !Yes 2 □ No		how injury occ	urrea	
3	Attendi	fica	3 ☐ Suicide 6 ☐ Could r	ot be	Injury - At home, farm, s		, 100 2 0 11		Street and Nur	nber or Rura	il Route Number,
	al or safter	Certification;	4 Homicide	building,	etc. (Specify)			City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificacompletely filled in by the funeral director,		29a. Certifier 1 Certifyin	g Physician: To the be examiner: On the basis	st of my knowledge, de	ath occurred at the ti	me, date and	place, and due to the	cause(s) and	nanner as st	tated.
	To the H within 24 To the Fi complete	Aedical	one)	and manner	stated.			occurred at the time,			
	To the within To the comple	Σ	29b. Signature and title of certifier	11/2		29c. Licens			29d. Date sign	1	Day, Year)
•	4		7600	1102	A death ():	D4	2532	_	15/8	104	
	U	117	30. Name and address of person	who completed cause of 211	T death (Item 23a) (Type	Ave 1	Baltim	cre MI)	2/20	7	
	Sta	itė	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	1		1	, 50		
	Regist		DEC 0 9 20	04 500	f death (Item 23a) (Type 2 Dunda (K strar's Signature	sparked					

	•	1 - State Registrar	State of Marylar	•	rtificate of I			Reg. No.	1001.	3896
nysici	an	1. Decedent's Name (First, Middle, Last	)				2. Date of Dea Month	Day		
Medic	ai	MARIA 4a. Facility Name (If not institution, give	street and number)		DENR I	LCH r Location of Deat	DECEMBO		County of De	
xamin	ier	SINAL HOSPITA		MORE			CITY	102		/A
eral		5. Social Security Number 6. Se	X X 7. Age (In yrs.	. last birthday)		If Under 24 Hrs Hours Min.	(Month, Day	(, Year)	0.0	
tor		220-52-3036	JM 2017 85	Yrs.			08/01/1	1919		RUSSIA
B	_	10a. State 10b. County		ity, Town or Lo						10d. Inside City Limi
other traumatic evant, the Medical Examinar must be notified at	ecto	FL PALM BE	ACH BC	DCA RAT				40- 0''		1 Yes 2□N
a d	Funeral Director	10e. Street and Number 7704 TRAVELERS TR	EE DRIVE		10f. Zip Code 33433			-	zen of What (	Country?
	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No-			nerican Indian,
	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	io mount oto-,	Ì		WHITE
	ted b	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occupa	ation		16b. Kin	nd of Busines	s/Industry
	Completed	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of wo i)	rking			•
		12 17. Father's Name (First, Middle, Last)		HOUS	EWIFE	19 Mothor's No.	me (First, Middle,		HOME	
	To Be	LEIB		SA	LEM	RACHEL	me (riist, widde,	walden .	Sumamer	MARCUS
	-	19a. Informant's Name/Relationship (T)	ype, Print)		ng Address (Street a		ural Route Numbe	r, City or	Town, State,	
			GHTER		GOOD LIO	ON RD. CO	The second secon			
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crer	osition (Name of matory or other place		Date			or Town, State
, mi		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Ligens</li> </ul>			MORIAL PA		7/2004			TNC
once.		1 0/15/11			<ol><li>Name and Address</li></ol>	ss of Facility	II I FV I N	VIIIV V	A REILY	
		Suatto 11.	better			ss of Facility S( ERSTOWN				, MD 21208
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea	8	900 REIST	ERSTOWN	ROAD - F	IKES		Approximate Interval Between
		shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that caused the dea ne cause on each line.	8	900 REIST	ERSTOWN	ROAD - F	IKES		, MD 21208
ı		shock, or heart failure. List only o Immediate Cause (Final	lications that caused the dealine cause on each line.  a. Hemowh  Due to (or as a conserved)	ath. Do not ent quence of):	900 REIST	ERSTOWN	ROAD - F	IKES		Approximate Interval Between
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DHMH 17 Rev 1/2001

State Registrar DARSHANA
31. Date filed (Month, Day, Year)

DEC 0 9 2004

PURDHIT, MBBS
32. Registrar's Signature

DHMH 17 Rev 1/2001

VERTELL

ELMANITAR A WAY

αı			State Amend Iter	State of 1&Unpend	f Maryland / Der Item 23a&2/	artment of H per me Go	lealth ar Death	d Mental Hy 16-05 tas	giene	1 00001
	<b>O</b> l-1-1-1-1	3 t	Decedent's Name (First, Midd					2. Date of De	ath LUU	3. Fime of Death
	Physici /Medic		Aloysius		Α.	Fox		Decembe		04" 8:20 p M
4	Examin	er	4a. Fecility Name <i>(If not i</i> ns <i>titutio</i> 5110 Roundhill		,	4b. City, Town, or		Death	4c. County of	of Death
0	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthday		If Under 24	Hrs. 8. Date of Birt	th Vanal	Birthplace (State or Foreign Country)
	Director		219-42-6933	1 <b>∑</b> M 2□F	58 Yrs.	Months Days	Hours	Hrs. 8. Date of Birt (Month, Da 10 3	1 46	MD MD
7	and		Usuel Residence of Decedent  10a. State 10b. County	,	10c. City, Town or L	ocation				10d. Înside City Limits
	Maryland -f show fled at	tor	MD NA		Baltimo	re				1 X Yes 2 □ No
	or 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	death with the rms 23a or 28a r.must be noti	rai C	5110 Baltimo			212			U.S.	
		Funerai	11. Marital Status  1 Never Married Mar	Armed Fo	edent Ever in U.S. 13. proes?	Was Decedent of H If Yes, specify Cuba	ispanic Drigir an, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	- 14. Race Black	- American Indian, r, White, etc.
036	72 hours after natural, or Ite	by	3 Widowed 4 Divorced	If Yes, Gir	V8	1 ☐ Yes 2 X No	Specify:		Specify:	Black
Maryland 21215-0036	72 ho natur	Completed	15. Deceder	nt's Education est grade completed)	(Giv	edent's Usual Decupa	durina most a	of working	16b. Kind of Bus	siness/Industry
121		mpi	Elementary/Secondary (0-12)	Colfege (	1-4or 5+) life.	DO NOT use retired	1)		C - m 1	M-F
2	filed within Hygiene. other than	e Co	12th grade  17. Father's Name (First, Middle,	Last)	Asse	mble Lin		Ker s Name (First, Middle,		Motors Co.
an	id be lental ked o	To Be	Aloysius Fox					beth Whi		,
ary	should and Men s marks umatic	-	19a. Informant's Name/Relations		19b. Mai			or Rural Route Numbe		State, Zip Code)
	es 1 and 2 should be filed of Health and Mental Hygie of Health and Mental Hygie if item 27 is marked other ir other traumatic event, it		Elizabeth Ha	mpton-Si				Street,		
Baltimore,	ges 1 t of Hi ff iter or oth		20a. Method of Disposition 1   1   Burial 2 □ Cremation	3 □Removal from	State 20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	:e)	Date	20c. Location - C	City or Town, State
Ħ	permit. Pages Department of I important: If ite any injury or of		*4 ☐ Donation 5 ☐ Other (S						Randall	stown, Md
Ba	permit. Departr imports any inju		- Rme	4.	moren M	2. Name and Address arch F/H	West	: 'e, Balti	mara. N	id 21215
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that of	aused the death. Do not er					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		etic Ketoacid	osis				Doset and Death
	/Medical Examiner		resulting in death)	а.	(or as a consequence of):			· · · · · · · · · · · · · · · · · · ·		
	LAMITHIE	70	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a consequence of):					
	ted nsit	Examiner	Cause (Disease of Injury	<b>4</b> Due to	(or as a consequence or).					
Ć	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	c. Due to	(or as a consequence of):					
8760,	6 % 6	lical		d		<u> </u>				
9	leath certifica attending ph I for use as th	9	IF FEMALE:						-	
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t		□Ectopic pregnancy □ Other (specify)	•		23d. Date Mont	of delivery th Day Year
P.O.	t the de by the tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkn		Other (specify)				
	res that igned b	by Pł	Part ff. Dther significant conditi	ons contributing to d	eath but not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contrib	bute to the cause of death?
ords	w require been sig should b							1 🗆 Y	es 2000 3	3 ☐ Probably 4 ☐Unknown
Vital Records,	law ri las be	Completed						24a. Was	sv pr	ere autopsy findings available ior to comptetion of cause of
al B		Con							rmed? de 2□ No 1	eath? Yes 2 No
V.	Attending Physician: The death. sctor: After this certificate by the funeral director, pag	o Be	25. Was case referred to medica examiner?  1 X Yes 2 No	Hospital:	Inpatient 2 ER/Outpatie	int 3□ DOA Dthe		Death (Check only o		- Coopo
o.	g Physer this seral d	H-	27. Manner of Death	28a. Date	of Injury 28b. Time		4 □ Nursi		now injury occurre	(Specify) SCENE
Division	uttending death. ctor: After y the funer	Certification:	E C / tooldont	igation	th, Day Year) Injury		k? Yes 2. □No			
Νį	or Atts after de Directo	rtific	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	of Injury - At home, farm, sing, etc. (Specify)	treet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
Ω	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Ce	29a, Certifier 1 ☐ Certifyi	na Physician T- the						
	24 ho 24 ho Fund etely f	edical		Exeminer: On the b	<ul> <li>best of my knowledge, dea asis of examination and/or in ner stated.</li> </ul>	th occurred at the time nvestigation, in my of	ne, date and p pinion, death	occurred at the time, o	cause(s) and man date and place, ar	ner as stated.  nd due to the cause(s)
	To ths within 2 To the complet	Me	29b. Signature and title of certific	er /	1/1	29c. License	e number		29d. Date signed	(Month, Day, Year)
			XX	My	10		OCME	D	ecember	7, 2004
-	1		30. Name and address of person	who completed days						
			31. Date filed (Month, Day, Year	1 19 1	111 Registrar's Signature,	Penn Str	eet, B	altimore,	MD 21201	
	Sta Registi		DEC 0 9 20		of the state of th	Sparke				
			שבט טשל בנ	VT /		7				

State of Maryland / Department of Health and Mental Hygiene  1- For Unpend Item 23a&27 per me G840 2-9-05 tas  Certificate of Death  Reg. No. 0 14 38955							
	Physici		1 Decedent's Name (First, Middle Last)	2. Date of D Month	eath Day Year	3. Time of Death	
5	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)  GOOD SAMARITAN HOSPITAL  4b. City, Town, or Location of Deatl BALTIMORE CITY	DECEMB	ER 5,2004 4c. County of Deal	9:40a	
	Funeral Director	2	5. Social Security Number  13-71-2796  12M 2 F  3 Nowths  Months  Days  Hours  Min.	8. Date of Bi	nth 9. Bird 4 19. Bird 9. Bird	hplace (State or Foreign buntry) WY/WD	
	72 hours after death with the Maryland historical for Items 23a or 28s-f show dical Experiest must be notified at	tor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	rs after death with the Mar I', or Items 23a or 28a-f at Marinet munt be notified	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?	
	er death w Items 23a	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or N to Rican, etc.)	0- 14. Race - Ame Black, Whit		
5-0036	ours afte	by	Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: 1 Yes 2 No Specify:		Specify:	lacic	
215-0	d within 72 hours plene. Ir than "naturel".	Completed	15. Decedent's Education (Specify only highest grade completed)  Eleftentary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work iffe. DO NOT use retired)	rking	16b. Kind of Business/	Industry	
2		e Com	Intant Intant	me (First Middle	A Maiden Sumame)	aut	
Maryland	be od o	To Be	Juwan Foster Yuc	nne	GOOD		
	nd 2 shulth and 27 is m		19a Informant's Name/Relationship (Type, Print)  Aut 19b. Mailing Address (Street and Number or Plus Act 1)  19b. Mailing Address (Street and Number or Plus Act 1)	aral Route Numb	per, City or Town, State, 2	Zip Code) のコロリ	
Baltimore,	00		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	c. Location - City or	Town, State	
altin	permit. Pag Department Important: I any injury o	Ì	4 □ Donation 5 □ Other (Specify)  21. Signative of Funeral Service Licensee  22. Signative of Funeral Service Licensee	7/04	DOLITIMON	CON P.A.	
8	825 2 3		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	ord, I	Sc/to-MD	2/2/2 Approximate	
	Physician		Immediate Cause (Final disease or condition Sudden Infant Death Syndrome			Interval Between Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
X	rted nsit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury				
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89	tificate be ex ng physician as the buria	edical	d				
P.O. Box	eath cer attendir for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deli Month	very Day Year	
	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute to Yes 2 XNo 3 ☐ Pro		
Division of Vital Records,	The law re ate has bee page 2 sho	Completed		24a. Was auto perfe		topsy findings available completion of cause of	
Vita	yeicien: This certificate director, pag	o Be C	25. Was case referred to medical examiner?  1. The patient STAR (outpatient 30 DOA Other: 4 Nursing H	th (Check only	one)		
n of	ding Phyen.  After this funeral di	$\vdash$	27. Manner of Death 1 1 1 Natural 5 Pending 1 1 Natural 5 Pending 1 1 Natural 5 Pending 1 Natural 5 Pendin		dence 6 Other (Spec how injury occurred	ify)	
ivisio	or Attendi	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28f. Location ( City or To	Street and Number or Ru wn, State)	ral Route Number,	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fr	edical Ce	29a. Certifier  (Check only only)	, and due to the	cause(s) and manner as date and place, and due	stated. to the cause(s)	
	To the within ?	Med	29b. Signature and title of certifier  OCME  29c. License number		29d. Date signed (Month	ı, Day, Year)	
		*	Mate a Gran Tollers			2004	
	de l	7	PATRICIA A. Aronica-POllakasti PENN STREET, BAL	TIMORE,	MARYLAND 21	.201	
	Sta Registr	10	DEC 0 9 2004  31. Date filed (Month, Day, Year)  DEC 0 9 2004  32. Registrar's Signature				

			1- For State Registrar		laryland / Dep	artment of Hea	alth and Me	ntal Hygie	_	38966
	į		Decedent's Name (First, Middle, L.)	.ast)		rimodio or Bo		. Date of Death	NOT O O IN	3. Time of Death
	Physic /Medi Exami	cal	Yale Fineman Dece				December	Day Year 2, 2004  4c. County of Dea	9:30 a <sup>M</sup>	
1	Exami	iei	3402 Pendleton		,		r Spring			
	Funeral			Sex 7. A	ge (In yrs. last birthday	If Under 1 Year If	Under 24 Hrs. 8	. Date of Birth		thplace (State or Foreign ountry)
	Director		172-42-6824	1 □XM 2 □ F	53 Yrs.	Months Days H	lours Min.	Dec. 2,	1951 P	ennsylvania
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural, or itams 23a or 28a-f show event, the Medical Exam was not be a pulled at	Funeral Director		ntgomery	Silve	r Spring				1 ☐Yes 2 ☐ No
	with a or	늅	10e. Street and Number 3402 Pendleton	Drizo		10f. Zip Code		10g.	Citizen of What Co	•
	leath	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13	20902	nic Origin? (Specif	Vac of No	United	
9	or itar	E		Armed Forces	?	Was Decedent of Hispar If Yes, specify Cuban, M		an, etc.)	Black, Whit	e, etc.
93	ours a	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give A Year or Dates:		1 ☐ Yes 2 ☐XNo Si	pecify:		Specify:	white
5-	72 h "natu	Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	16b.	Kind of Business	Industry
121	within ane. than	dm	Elementary/Secondary (0-12)	College (1-4or	2+)				Entertai	nment
d 2	filed with Hygiene. other thar ent, the N		17. Father's Name (First, Middle, Las		) <u>                                    </u>	Musician 18.	Mother's Name (F	First, Middle, Maid	en Sumame)	
an	should be filed withing and Mental Hygiene.  s markad other than umatic event, the Man	To Be	Edward Fineman	า			Frances			
Maryland 21215-0036			19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and I	Number or Rural R	oute Number, Cit	y or Town, State, 2	Zip Code)
≥ .	1 and 2 Health a em 27 is	0.3	Carol Fineman, v	vife	340	2 Pendleton	n Drive,	Silver S	pring, M	D 20902
ore	of Heal		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, cre	natory or other place)	Date		Location - City or	
Ë	Pages tment of t tant: If ite jury or of		* 4 □ Donation S □ Other (Spec	eify)	Chesape	aké Cremato	ory 12/8	/04 Be	ltsville	, MD
Baltimore,	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Lice	ensey //A	Alhow 2	2. Name and Address of Rapp Funera	Facility	emation	Services	
			23a Part I. Enter the disease, or co	mplications that cause	aure	933 Gist Av	enue Sil	ver Spri	ng, MD	20910
	Š.,,,,,,		shock, or heart failure. List onl Immediate Cause (Final	y one cause on each i	ine.		ocii as caldiac oi le	sspiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		noma of Lu s a consequence of):	n <sub>E</sub>				
	Examiner			Diabe		ry Artery D	isease			
	'n	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of):	, ,				
Vii	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	cate be executed physician and the burial-transit	E	resulting in death) cast	Due to (or as	a consequence of):					
. Box 68760,	physicate I	edical	•	d						
9 X	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				004 D-1(-4-17	
Box	death d for u	Physician/M	in the past 12 months?	1 Live birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.0	at the de by the a tached t	hys	9 Unknown	9□ Unknown						
	law requires that the as been signed by th 2 should be detache	ру Р	Part II. Other significant conditions	contributing to death t	out not resulting in the u	nderlying cause given in	Part I.	23e. Did tobacco	use contribute to	the cause of death?
Vital Records,	w require been si should b							1 ី Yes	2□No 3□Pro	obably 4 Unknown
ecc	e law r has be je 2 sh	ompleted						24a. Was an autopsy	24b. Were au	topsy findings available
E	ate pag	Sol						performed?	death?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Place of Death (C	heck only one)		
of	Phys this al dir	<u>۲</u>	1 ☐ Yes 2 🗓 No 27. Manner of Death	1 Inpatio	ent 2 ER/Outpatier		□ Nursing Home			ify)
_	Ing Witer	tion	X□Natural 5 □ Pending	28a. Date of Inju (Month, Da	ly Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		Describe how inj	ury occurred	
Division	r Attending er death. ractor: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not	28e. Place of In	jury - At home, farm, str			Location (Street a	and Number or Ru	ra I Route Number
Ö		erti	4  Homicide	building, ef	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, Sta	te)	arriodio rioribor,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fo	edical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	if examination and/or in	occurred at the time, day	ate and place, and n, death occurred a	due to the cause( at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the Complet	M	29b. Signature and title of certifier	1/1/1/1		29c. License num	nber	29d. D	ate signed (Month	, Day, Year)
			> HU.	Ille		125	7/19		Ber.	6 7004
	. 0		30. Name and address of person who			,				• 0007
	10		Dr. Pamela Mu			ood Drive,	#205 Silv	er Sprin	ng, MD 2	0901
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 9 20		ar's Signature	Sparker				

			- FOI	artment of Health and Mental Hertificate of Death	Reg. No. 2004 38967
	Physici	an	Decedent's Name (First, Middle, Last)     SUSAN CARROLL FRICK VON MAUR	2. Date of Month	Death Say Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death
	Funeral Director		5. Social Security Number 219-44-7263 6. Sex 1 M 2 XF 62 Yrs.	Months   Davs   Hours   Min.   (Month)	Birth Day, Year)  3, 1942  9. Birthplace (State or Foreign Country)  MARYLAND
Maryland 21215-0036	Maryland	Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits 1 X Yes 2 □ No
	h with the		10e. Street and Number 4100 NORTH CHARLES STREET	10f. Zip Code 21218	10g. Citizen of What Country? USA
	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, if e Medical Exacting must be multised at ODGe.	by Funera	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ KNo Specify:	No- 14. Race - American Indian, Black, White, etc.  Specify: WHITE
	Jwithin 72 ho jiene. r than "natur It e Medical I	ompleted	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) IOMEMAKER	16b. Kind of Business/Industry OWN HOME
land ?	uld be tiled Mental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) ROBERT DENISON FRICK	18. Mother's Name (First, Midd CATHERINE F	
	and 2 sho salth and I n 27 is ma er traums		CATHERINE RANDALL niece 307	ling Address (Street and Number or Rural Route Num OVERHILL RD BALTIM	ORE, MD 21210
Baltimore,	Pages 1 and of He ant: If iten		1 □ Burial 2 □ Kremation 3 □ Hemoval from State  '4 □ Donation 5 □ Other (Specify)  GREEN M	ematory or other place) 10UNT CEM. 12/13/200	
Balt	permit. Departn imports any inju		* EAMONACO	22. Name and Address of Facility HENRY W 16924 YORK RD. MON	KTON, MD 21111
. Box 68760, 🔨	Physician /Medical Examiner  physician and physician are percented the physician are p	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		y arrest, Approximate Interval Between Onset and Death 24 hours
	death certific e attending p d for use as	Physiclan/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
ds, P.O.	es pe	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the	and any ing occording to the control of the control	d tobacco use contribute to the cause of death?
on of Vital Records,	The ate h page				rtopsy prior to completion of cause of death?
	Attending Physician: Thradeath. r death. ector: Atter this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner?  1  Ves 2 No  1  No Hospital: 1 Inpatient 2  EFVOutpatie  27. Manner of Death 1  Natural 5 Pending 2  Accident investigation		ly one) asidence 6 □ Other (Specify) se how injury occurred
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely tilled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
	the Hospi in 24 hour the Funeri pletely tills	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea (Check only one)  1 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s)
<b>•</b>	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number ATZY38916	29d. Date signed (Month, Day, Year)  December 5, 2004
	\0 Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Driversity Parkway, Bultin	
	Regist	rar	BER A BROOM Source	I had	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 25, 2004 Pearl Flohr November 7:45 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Frederick North Hampton Manor Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🛛 F Yrs. 90 Director 213-18-8923 May 31, 1914 Maryland Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other trauments average. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Frederick Frederick 1 ☐ Yes 2 📉 No **Funeral Director** 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 200 E. 16th Street 21701 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondery (0-12) 12 College (1-4or 5+) secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Myrtlen Robert Sheets Susan Margaret Cecil 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Gambill/daughter 1201 Staley Avenue Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD ericin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner is cartificate has been signed by the attending physicien and director, pega 2 should be datached for use as the buriel-transit Physician: The law requiras thet tha daath certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes Marko 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 Inpatient 3□ DOA rsing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient this eral Director: After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation Injury Matural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide aftar within 24 hours a

To the Funeral C

complately filled 29a. Certifie eritifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check on 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar 30. Name end address of person of COSPUS (1)
31. Date filed (Month, Day, Year)

no completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

		For	State	of Marylan	•	artment of H		Mental Hygi	200	1. 20000
		Registrar  1. Decedent's Name (First, Midd	dle. Last)		Ce	Tuncate of	Dealii	2. Date of Death	g. No. C U U	3. Time of Death
Physicia		Earsell	_	. •		Hans	3	Month Decembe	er 7 200	
/Medica Examine	# }	4a. Facility Name (If not institution				4b. City, Town, o			4c. County of De	
		Alice Manor N	Nursing	Home		Baltimo				
Funeral		5. Social Security Number	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rear) (	irthplace (State or Foreign Country)
Director		239-36-6095 Usual Residence of Decedent	X	82	113.			06 10	22	NC
yland	Ì	10a. State 10b. Count	у	10c. Cit	ty, Town or Lo	ocation	-			10d. Inside City Limits
a-fat	cto	MD NA	A	Ва	altim	ore				1XXX es 2 ☐ No
or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What (	Country?
ath w	ra .	2443 Shirley	Ave				215		U.S.A	
er de Itama	Funeral	11. Marital Status	Armed	ecedent Ever in U Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nerican Indian, lite, etc.
urs aft	by	1X Never Married 2 Ma 3 Widowed 4 Divorce	If Yes.	s <b>2√⊡√N</b> o Give rDates:		1 ☐ Yes XXNo	Specify:		Specify: B	lack
			ent's Education	d)	16a. Dece	dent's Usual Occup	ation	nting 1	6b. Kind of Busines	
ithin 7	Completed	Elementary/Secondary (0-12)	est grade complete College	(1-4or 5+)	life.	DO NOT use retired	d)	iking .		
filed with Hygiene. Other ther		l2th grade	<u>na</u>		<u>]</u>	Domestic		(C' ) 1'-(G' ) 1	Pri	vate
ed tal	Be	17. Father's Name (First, Middle						me (First, Middle, Ma	aiden Surname)	
ally id should nd Men marke umatic	2	Hezekiah Har			19h Maili	no Address /Street	Jane F	ural Route Number,	City or Town State	Zin Code)
Mar id 2 sho ith and 27 is my traum		Earsell Stat		htor					11.00	
Health Health tem 27 other tr		20a. Method of Disposition	_OII-Daug	20b. F	Place of Dispo	sition (Name of matory or other place	AVE	Baltimor Date 2	Oc. Location - City of	
0 0 = 5		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (	i 3 □Removal fro (Specify)	III State			1	12/8/04	Raltimo	ro. Md
Dallilli permit. Pag Department Important: any injury o once.	Ì	21. Signature of Funeral Service		. /	22	Name and Addre	es of Facility	12/0/0#	Darcino	Le, Ma
B B B B B		Alken	re H.	Thump	ow 4	arch F/H	West sh_Ave	, Baltim	ore. Md	21215
		23a. Part1. Enter the disease, on the art failure. Lis	or complications that st only one cause of	it caused the deat	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arres	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	2	Re	2C+9	1 616	reding	٩		Onset and Death
/Medical Examiner		resulting in death)	Due 9	to (or as a conseq	uence of):		-	,	1 1	
	_	Sequentially list conditions,	b. ————	to (or as a conseq		remi	9 20 4	0 1000	2201 1	
V值 慧·	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>₹</b>			C -1 -	· · · ·	10000		
sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	to (or as a conseq	Juence of):	1 grte	en a	1sesse		
bur bur	dical		d.		pne	umon	18			
The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	ed				4					
wrequires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pregnancy			23d. Date of d	,
be att	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of d		Other (specify)			Month	Day Year
d by t	Phy	9 ☐ Unknown  Part II. Other significent condit	tions contributing to	doath but not roa	ulting in the u	adarbias aguas su	en in Dort I	22a Did toba	LOCO USO COSTRIBUTO	to the cause of death?
signe d	ò	Taitii, Other signmoon contain	_	beh (			ori ii i i aiti.			Probably 4 Unknown
law requires t as been signe	etec			20-91				24a. Was an		autone, findings available
has ge 2 s	Completed							autopsy performe	ed?   death?	autopsy findings available completion of cause of
ician: The certificate ector, pa	မ င်	25. Was case referred to medic		12410	- 918	sender		1 ☐ Yes 2 ath (Check only one)	XNo 1 □ Ye	s 2X No
vaicia s cert	To Be	examiner?	Hospital:	□Inpatient 2□	ER/Outpatier	nt 3 DOA Oth		Home 5 Residen	ce 6 □Other (So	ecify)
g Phy g Phy er this		27. Manner of Death	28a. Da	te of Injury onth, Day Year)	28b. Time o			28d. Describe how		
ath.	atlo	Z / tooldont	tigation	onin, bay roup	in you y		Yes 2 □ No			
INTERPLET OF Attending after death. Director: After in by the fune	ertification;	3 Suicide 6 Could 4 Homicide deter	d not be mined 28e. Pla	ice of Injury - At he	ome, farm, sti fy)	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
urs af ura i D	O									
To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funaral Director: After this certificate has completely filled in by the funaral director, page 2	edical	29a. Certifier 1 Certify (Check only one) 1 Medica	at Exeminer: On the	the best of my kno basis of examina anner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner a e and place, and du	as stated. ue to the cause(s)
Within To th	ĕ Z	29b. Signature and title of certif	ier .			29c. Licens			d. Date signed (Mor	
							8115		12/8/4	
5		30. Name and address of perso	on who completed ca	ause of death (Iter	n 23a) (Type, 26 C	Print) TOLIDE	MY H	GTS A	ve Ba	14.1 mo 21215
Stat Registra		31. Date filed (Month, Day, Yea DEC 0 9	(r) 32	. Registrar's Signa	dure	Spark	· ·			11.1 mo 21215

821		Please Type or Print in Bla		•	•
		State of Maryland 1 - State of Maryland 23a,27,28a-f per	/ Department of Hear r Re C839, 1-20 r Bertificate of De	alth and Mental Hygic 05 Path	2004 38970
Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
/Med Exam	ical	4a. Facility Name (If not institution, give street and number)	TCHENS  4b. City, Town, or Lo	December	4, 2004 1811p M
Exam	ner	114 N. Hilton Street	Baltimore		
Funera Directo		5. Social Security Number 6. Sex 10 M 2 F 7. Age (In yrs Jast		Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country) (AND MAKY LAND
Maryland -1 show	tor	/1	own or Location		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. Ite Malcul Examiner must be notified at	Funeral Director	10e. Street and Number 114 N. HILTON St.	10f. Zip Code	21229 10g	Citizen of What Country?
er death Items 2	unera	11. Marita Status  12. Was Decedent Ever in U.S.		anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
0036 nours aft iral', or	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 M No S	Specify:	Specify: DLACK
21215-0036  d within 72 hours at giene. er than "natural", or the World Express.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	<ol> <li>Decedent's Usual Occupatio (Give kind of work done during life. DO NOT use retired)</li> </ol>	ng most of working	b. Kind of Business/Industry
d 212 filled with Hygiene other the	Con	17. Father's Name (First, Middle, Last)	DUTCH	Mother's Name (First, Middle, Ma	FOOD
Maryland of 2 should be fill th and Mental Hy 27 Is marked oth traumatic event	To Be	RICHARD HITCHENS		FRANCIS C	HASE
Mary d 2 sho th and I to 1s me traume		19a. Informant's Name/Relationship (Type, Print)  DANIEUE STOKES (DAUGHTER)	9b. Mailing Address (Street and 27 11 0 2)	Number or Rural Route Number, C	City or Town, State, Zip Code)  BALTO, MO 21244
ges 1 and tof Health It is tem 27 or other tr		20a, Method of Disposition 20b, Place	of Disposition (Name of othery, crematory or other place)	Date 20	c. Location - City or Town, State
altimore, rmit. Pages 1 ar partment of Hee portant: If frem y injury or othe		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	eus Cemetery	1 12.11.04 BA	TIMORE, MARYLAND
Baltin permit. P Departm Importar any injur		Vauda Tree	4905 YORK	RUAD BATINI	GREENE FUNERAL HM.
		23a. Part1. Enter the disease or complications that caused the death. I shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, s		
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Narcotic and c  Due to (or as a consequent		ition	Oliset and Oeath
Examiner	١.	Sequentially list conditions. b.			
rted Insit	Examiner	if any, leading to immediate Due to (or as a consequent cause. Enter Underlying Cause (Disease or injury	ce of):		
68760, ficate be executed physician and ts the burial-transit		that initiated events resulting in death) Last	pe of):		
68760, tificate be ex ig physician as the buria	dical	d. =			
Box 687 leath certificate attending phys for use as the	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal dea	ath 3 Ectopic pregnancy		23d. Date of delivery
S, P.O. B( es that the death igned by the atte be detached for	Physician/Media	in the past 12 months?  1   Yes 2   No 9   Unknown 9   Unknown			Month Day Year
S, P.	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in	Part I. 23e. Did tobac	co use contribute to the cause of death?
cords w require been sig				1 ☐ Yes	
I Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending phys page 2 should be detached for use as the	Completed			24a. Was an autopsy performed	
Vital Fidelian: The certificate	BeC	25. Was case referred to medical examiner?		. Place of Death (Check only one)	No 1 □Yes 2 □ No
of V Physic Physic rthis co	2	1  Yes 2  No		4 ☐ Nursing Home 5 ☐ Residence 28d. Describe how	e 6 Nother (Specify) at scene injury occurred unk
sion c anding P ath. or: After ne funera	ation	1 Natural 5 Pending investigation 12 4 Pod 4 Pay Year) 6:	0. Time of 28c. Injury at Work? 00 M 1 ☐ Yes		ulik
Division of Vital Records, or Attending Physician: The law requires tafter death.  Director: After this certificate has been signed in by the funeral director, page 2 should be a	Certification:		farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number of Rural Route Number State) 114 N. Hilton St.
ospita hours uneral ly filled	edical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	dge, death occurred at the time, o	Baltimore	e(s) and manner as stated.
Te the H Within 24 To the Fi	Medi	one) and manner stated.  29b. Signature and title of certifier,	29c. License nu		Date signed (Month, Day, Year)
THE		Mayrie me Kull in	OCME	De	cember 5, 2004
THE		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Print) 111 Penn	Street, Baltimo	re, MD 21201
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	-		
Regis	rar	DEC 0 9 2004	Societie .		

DHMH 17 Rev 1/2001

		For 1_ For	State of Marylar	nd / Depa	artment of He	alth and M	_	_	38971
		Registrar		Cel	rtificate of D	eatn		. No.	
Physic /Medi			SEPH HA	JNL	EY, Sr		2. Date of Death Month DECEMBER		
Exami	ner	4a. Facility Name (If not institution, g		0.6. 5	4b. City, Town, or L		=	4c. County of Deal	h
Funeral Director			YA MEDICAL Sex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year	TIMOR If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y December		hplace (State or Foreign unitry) Maryland
ō.		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo	nantina		December	1,1333	10d. Inside City Limits
e Maryla sa-f shov	ctor	Maryland Hari		el Air					1 Yes 2 No
with the a or 21	Funerai Director	10e. Street and Number 1310 Sheridan Pl	Lace		10f. Zip Code 21015		10g	i. Citizen of What Co USA	ountry?
death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto F	cify Yes or No-	14. Race - Ame Black, Whit	
if. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ritment of Health and Mental Hyglene.  ortant: If itam 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic avant, it a Modical Examinal must be notified at a	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced				Specify:	,		nite
72 ho	eted	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of workir	ng 16	b. Kind of Business	Industry
within lene.	Completed	Elementary/Secondary (0-12)	College (1-4ar 5+)		r & Operat			Automobi.	le Dealer
ylalla 2 12 buld be filed with Mental Hygiene arked other tha	Be C	17. Father's Name (First, Middle, La	st)		1	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
should band Ment	5	Felix John	Hanley	405 14-25	ng Address (Street an	Mary	Mitilda		
Mar od 2 sho lth and 27 is m		19a. Informant's Name/Relationship Mary P. Hanley-			og Address (Street an O Sheridan				21015
permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra		20a. Method of Disposition 1	20b. I		osition (Name of matory or other place)		-	c. Location - City or	
Deficiency Pages Department of mportant: If it any injury or concern and injury or conce		`4 □Donation 5 □ Other (Spe	cify) Ja:		ville Cem.		04	Jarretts	ville, MD
Dermit Depart Import any in	1	21. Signature of Funeral Service Lice	Munde	M <sub>c</sub>	2. Name and Address Comas Fun 317 Cokesb	of Facility eral_Home	P.A.		3 21000
	-	23a. Part 1. En. or the disease, or co shock, or heart failure. List on	omplications that caused the dea	th. Do not ent	BT7 Cokesb ter the mode of dying,	such as cardiac o	<ul> <li>Abingdor respiratory arrest</li> </ul>	on, Maryla	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Pullmone						Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	ypertens	31011			- We   W 5
- Lanning	١.	Sequentially list conditions,	b. Concestive	Hec	rt tail	we			20 years
outed ansit	Examiner	Cause (Disease or injury that initiated events	Renal	failu	رح				5 days
FoU, ( )  be executed sician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
oo/o	dical		d						
death certifical death certifical eattending physical for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of o	aldeath 3[	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
the de	hysic	1 Yes 2 No 9 Unknown	9□ Unknown	30481 0				-	100
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	þ	Part II. Other significant condition	9	sulting in the u	nderlying cause given	n in Part I.			the cause of death?
He The lar te has age 2	ompieted						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
VICAL ician: T	BeC	25. Was case referred to medical examiner?		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		26. Place of Death		2110	
Or Vita Physician: rthis certific ral director,	P	1 ☐ Yes 2 ☑ No 27. Manner of Death	-	ER/Outpatie		4   Nursing Hor	ne 5 Resident	ce 6 Other (Spe	cify)
	tion	1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year)	Injury	Work?	es 2 No	od. Describe now	injury occurred	
JIVISION I or Attanding after death. Director: After	Certification;	3 Suicide 6 Could no 4 Homicide determin	t be 200 Blace of Injury - At h	nome, farm, st. ify)	reet, factory, office	2	28f. Location (Stre City or Town, .	et and Number or R State)	ural Route Number,
UNISION  To the Hospital or Attendin, within 24 hours after death.  To the Funeral Director: Alt completely filled in by the fun	Medicai Co	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kn (aminer: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the time evestigation, in my opii	e, date and place, a nion, death occurre	and due to the cau ed at the time, date	se(s) and manner as a and place, and due	s stated.  to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier			29c. License	number	290	. Date signed (Mont	h, Day, Year)
		Pila	V MD PK	D	P18	561	D	ecember	3,2004
5+1		30. Name and address of person w			Print) eene S	· - 0	ĭ 1.		0.00
9	tate	31. Date filed (Month, Day, Year)		ature	eene s	21, 59	# HIMOSI	) mo	41401
Regis		DEC 0 9	2004 General	- La	Ann. d				

DHMH 17 Rev 1/2001

SIMODESTINE

			1- For State Registrar	of Maryland / Dep	artment of Health and N rtificate of Death	fental Hygi	en2004	38973
	D		1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
-	Physic /Medi		Janet Jones			Month /2	Day, Year	9:17am
-	Exami		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		4c. County of Deat	h
		Ш	University of Maryland Hos	igital	Baltimore		Baltimo	re C.fu
	Funeral		5. Social Security Number / 6. Sex	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, )	(ear) 9. Birti	hplace (State or Foreign untry)
	Director		220-64-4689 Usual Residence of Decedent	48		10 31		ermany
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-1 s	ctor	MD NA	Baltimo	re			1 X Yes 2 □ No
	ith the	Director	10e. Street and Number		10f. Zip Code	109	g. Citizen of What Co	untry?
	ath w	rai	715 Deacon Hill Ct	•	21225		U.S.A.	
	er de	Funeral	bemA	Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs aft	by F	1 Never Married X Married 1 Yes, 3 Widowed 4 Divorced Year o	s 2√No Give	1 ☐ Yes 25 No Specify:	•	Specify:	, 010.
21215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show Jical Examiner must be redified at		15. Decedent's Education	Dates.	dent's Usual Occupation	1.00	В.	Lack
215	within 72 ene. then "na	plet	(Specify only highest grade complete	(Give	kind of work done during most of worki DO NOT use retired)	ing 16	ib. Kind of Business/l	ndustry
21	d with	Completed	12th grade 2y	rs Admin	istrative Assis	stant Ar	chdioces	se of Balt
	be filed v tal Hygie d other I	Be (	17. Father's Name (First, Middle, Last)			(First, Middle, Ma		
yla	2 should be and Mental is marked reumatic ev	2	Clifford Henricks	Sr.	Jimmie H	Marding		
Maryland	C/ 42 100		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rura	l Route Number, C	City or Town, State, Z.	ip Code)
	l and fealth im 27		Ernest Jones Jr. H		Deacon Hill Ct		o, Md	21225
0	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal fro	m State 20b. Place of Dispo	sition (Name of patory or other place)	ate 20	c. Location - City or 1	own, State
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		`4 Donation 5 ☐ Other (Specify)	King Me	morial Park 12/	11/04 F	Randallst	own, Md
Bal	Depa Impo any ir		21. Signatule of Funeral Service Licensee	22 M	Name and Address of Facility arch F/H West			,
			23a Parti Enter the disease or complications the	1300 4	300 Wabash Ave.	Baltim	ore, Md	21215
н			23a. Part L. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final	n each line.	er the mode or dying, such as cardiac o	r respiratory arrest	•	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Imonary Ed.	the A			Oliset and Death
	Examiner		Due	o (or as a consequence of):	- 1			
		er	Sequentially list conditions, frany, leading to immediate Due to	o (or as a consequence of):	Failure			
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	h- Adamsto				
oʻ	an an rial-tr		requiting in death) Last	o (or as a conseque ce of):				
68760,	ificate be executed g physician and as the burial-transit	edicai	d. Lo	wer limb 1	schemia			
_	artifica ing ph e as t		IF FEMALE:				4	
Box	at the death certification of the attending particular is the attending particular is as as	Physician/M	23h Was decedent program 23c. If yes, c	outcome of pregna <i>n</i> cy birth 2  Fetal death 3	Ectopic pregnancy		23d. Date of deliv	,
0	the a	/sici	1	gnant at time of death 5	Other (specify)		Month	Day Year
<u> </u>	hat the		Part II. Other significant conditions contributing to	death but not reculting in the	debin Co. I	00 - 01444		
Vital Records,	The law requires that the tee has been signed by thoage 2 should be detached.	1 by	Mahd Obest	death but not resulting in the un	idenying cause given in Part I.		co use contribute to t	he cause of death?
Ö	w require been sig should b	etec	- I Bridge O Start	7				
ř	The law cate has page 2:	Completed				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
e e			05 11/1			performed 1□ Yes 2☑		2 No
	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 ☐ No Hospital:	Z	26. Place of Death			
O	g Phys ar this aral dii	-		Inpatient 2 ☐ ER/Outpatient e of Injury 28b. Time of enth, Day Year) Injury	- OLI OOK	re 5 ☐ Residence 8d. Describe how in	6 Other (Specif	(y)
DIVISION	or Attending I ifter death. Director: After in by the funer	atio	1 ⊠Natural 5 □ Pending (Mo 2 □ Accident investigation	onth, Day Year) Injury	28c. Injury at 2: Work?	00. D0001100 11017 11	niary occurred	
N N	of or Attendiated after death.  I Director: A d in by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place	ce of Injury - At home, farm, stre	et, factory, office	Bf. Location (Street	t and Number or Rura	Il Route Number.
5	tel or rs afte el Dir	Certification:	Bull	ding, etc. (Specify)		City or Town, Si	tate)	
	Hospitel or 4 hours afte Funerel Dir ely filled in	edicai (	29a. Certifier  (Check only 2   Medical Examiner: On the	ne best of my knowledge, death	occurred at the time, date and place, ar	nd due to the cause	(s) and manner as s	ated.
	To the Hospitel of within 24 hours af To the Funerel D completely filled in		one) and ma	nner stated.	estigation, in my opinion, death occurre	at the time, date	and place, and due to	the cause(s)
	To To con	Σ	29b. Signature and title of certifier	12.11	29c. License number	29d.	Date signed (Month,	Day, Year)
			- Child	Kantolif	RES-000		12/4/04	
	00		30. Name and address of person who completed car		Print)	0 11	11	
	20 Stat		31. Date filed (Month, Day, Year) 32.	Registrar's Signature	LEutaw Street	Baltin	ore, 170	
	Registra	- 51		merca &	land.			
_				1901	266 1860 Nov.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

			For State	State of Marylar				_	giene	0.01.	20071
			Registrar AMEND IT  1. Decedent's Name (First, Middle, Last,	EM #24a PER	S A Fightil	1983801L	29959/04	JH 2. Date of De	Reg. No.	JU4	3 6 9 / 4 3. Time of Death
ı	Physicia		TI	TI	nson.	Jr.		Month	Day	2004	5: 40 P M
>	/Medic Examin		4a. Facility Name (If not institution, give	0 1 1 4 4 4		b. City, Town, or	Location of Death			unty of Death	1
			Howard County G	eneral Hosp	ital	Colu	mhia		ŀ	loward	Λ
	Funeral		5. Social Security Number / 6. Sec	x 7. Age (In yrs. XM 2□F		f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year)	9. Birthpl Coun	ace (State or Foreign try)
	Director		29-10-6063 19 Usual Residence of Decedent		81 113.			01/00	7/19//		NID
	nyland how		10a. State 10b. County		ty, Town or Locati					10	Od. Inside City Limits
	8a-1 s	octo	MD HOWA	KU		essup		· · · · · · · · · · · · · · · · · · ·			1 ☐ Yes 2 ☑ No
	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or Items 23a or 28a-f show imatic avant, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 9950 Guilford	Rd. Apt. 3		10f. Zip Code	0794		10g. Citizen	of What Coun	á .
	death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was	s Decedent of His	spanic Origin? (S n, Mexican, Puert	pecify Yes or No	o- 14.	Race - America Black, White, e	
36	or Ite		1 Never Married 2 Married	17⊠Yes 2 No If Yes, Give		Yes 2 No	Specify:	o riican, etc.,		ecity: 12)	4CK
215-0036	hour tural	Completed by	3 KWidowed 4 Divorced  15. Decedent's Edu	Year or Dates:		t's Usual Occupa			16b, Kind	of Business/Ind	lustry
212	thin 72 9. 9n "ng Medi	plet	(Specify only highest grad	le completed) College (1-4or 5+)	life. DQ	NOT use retired)		king	11000	1100 0	o. Schools
2	led will		17. Father's Name (First, Middle/Last)	NIA		istodia	18. Mother's Nan	on /First Adidale	}		0.0000
Maryland	be ital	To Be		son, Sr.				Wilson	•	name)	
ary		ř	19a. Informant's Name/Relationship (Ty	ype, Print)			nd Number or Ru				
	is 1 and 2 of Health a itam 27 is othar trai		Deborah A. Gur	n/Daughter		-11101	Avenue	-		·	
ore	0 0		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ F	Removal from State	Place of Disposition	ory or other place	9)	Date 13.04		ion - City or To	
altimore,			<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licen</li></ul>		amson				-	)	3/100
Ba	permit. Departr Importe any inji		Canol C		I Va	Mann C	areche.	Furesa	I Ser Pike	Palto.	MD 21229
			23a. Part1. Exter the disease, or composhock, or heart failure. List only o	lications that caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a_Acute	MYOCO	irdia	inford	tion			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence (f):	Locale	crosis				VIONOC
	9	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Doe to (or as a consec				1	-		years.
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· athero	scloroti	ccar	diovusu	ular di	slase		years
8760,	icate be executed physician and s the burial-transit	al Ex	resulting in deathy East	Due to (or as a consec	quence os):						
687	ificate g phys as the	edical		d							
Box	th cert ending r use a	an/M	23b. was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		topic pregnancy			23d	Date of delive	*
Э. П	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o		ther (specify)				Month	Day Year
P.O.	that the ed by detac	/ Ph	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the unde	riying cause give	n in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
rds	quires in sign uld be		renal fa	ilure Ac	ute			1 🗆	Yes 2 🗷 N	lo 3 □ Proba	ably 4 🗆 Unknown
900	law requir as been si 2 should	Completed		,				24a. Was		4b. Were autop	sy findings available appletion of cause of
Ē	sician: The law certificate has t irector, page 2 s	Com						perfo	ormed?	death?	
Vita	sician: certific rector,	Be	25. Was case reterred to medical examiner?	Hospital:	1500	Othe	26. Place of Dea				
o	ding Physician:  After this certific funeral director,	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	3 DOA 28c. Injury Work	4   Nursing H	ome 5 Resi 28d. Describe		1-7	)
ion	anding Fath. or: After	atio	1 XNatural 5 ☐ Pending investigation	(Month, Day Year)	Injury		res 2□No				
Division of Vital Records,	l or Atta after de Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, street,	, factory, office		28f. Location ( City or To		umber or Rural	Route Number,
	Hospital or Attand 24 hours after death Funaral Diractor: etely filled in by the	al Ce	29a. Certifier 1 Certifying Phy	rsician: To the best of my know	owledge, death or	curred at the time	e. date and place	and due to the	cause(s) and	manner as sta	ated.
	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: Atter this certified completely filled in by the funeral director.	edical	(Check only 2 Medical Examione)	iner: On the basis of examination and manner stated.	ation and/or inves	tigation, in my op	inion, death occu	rred at the time,	date and pla	ce, and due to	the cause(s)
٠.	To the I within 2 To tha I complet	Ž	29b. Signature and title of certifier	VI V	0	29c. License	number	_ \	29d. Date si	gned (Month, L	Day, Year)
,			20 Name and address of	july in.	D / (T) T	DO	0382	50	Ve	c 05	2004
,	(5)		And rew Forb. M	ompleted cause of death (Ite	1111 //	tuxent	PKWY #	101 /	alum.	bia. M	n 21044
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign			/		_ U OUV	3/0/	41011
	Registi	ar	DEC 0.0 200/	E . Docker	And della	1					

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryland	Department of F Certificate of		ental Hygie	2001	38975
	DI dist		Decedent's Name (First, Middle, L	ast)			2. Date of Death Month	Day <t th="" year<=""><th>3. Time of Death</th></t>	3. Time of Death
4	Physici /Medic	al -	VERBIE JO	MMSON			DECEMBER	01,2004.	10.00 M
7	Examin	er	4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town,	or Location of Death		4c. County of Death	
			5. Social Security Number 6.	Sex 7. Age (In yrs. last	birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign
	Funeral Director			1□M 21XF 87	Yrs. Months Days	Hours Min.	Month, Day, Yo	9. 1917 Cour	
	0		Usual Residence of Decedent	100 000 7				,	Od. Inside City Limits
	anylar show	5	10a. State 10b. County		own or Location  OAL HIMERE				1 Yes 2 □ No
	the M	Director	10e. Street and Number	ja 2	10f. Zip Code		10g	. Citizen of What Cour	itry?
	3e or	5	1500 Edison H	Ghwa	2121	3		1150	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe	cify Yes or No-	14. Race - Americ Black, White,	
9	or ite		1 Never Married 2 Married	1 ☐ Yes 2 No	1 ☐ Yes 2 No		,	Specify: a 1	
5-0036	72 hours after death with the Maryland natural', or items 23e or 28a-f show dreal Examinet - ust be notified at	d by	3 Widowed 4 □ Divorced  15. Decedent's	Year or Dates:	16a. Decedent's Usual Occu	nation	16	b. Kind of Business/Inc	dustry
-51	in 72	Completed	(Specify only highest of Elementary/Secondary (0-12)		(Give kind of work done life. DO NOT use retire	during most of working	ng		,
2121	d within giene. er then "	mo	Elementary/Secondary (0-12)	N/a	Domestic	WUXKER	1	Dimestre	
	be filed tal Hygi d other event.	Be	17. Father's Name (First, Middle, La	st)		18. Mother's Name	(First, Middle, Ma.	iden Sumame)	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23e or 28a-1 show or other treumatic event. The Medical Examina	2	19a, Informant's ame/Rel ionship	(Time Print)	19b. Mailing Address (Stree	tand Number or Bura	Houte Number C	City or Town State Zin	Codel
Mai	d 2 sho th and ?7 Is ma treum		Joseph Johnson		1730 Facest PA		-	a, MD 20	
	f Heal item 2	1 3	20a. Method of Disposition	20b. Plac	e of Disposition (Name of etery, crematory or other pla	D		c. Location - City or To	
E O	Pages nent of int: If it		1 Burial 2 Cremation 3  1 Donation 5 □ Other (Special Control	Hemoval from State	/	12/9	104 2	BAI FIMORE	10
3altimore,	permit. Page Department of Importent: If any injury of once.		21. Signature of Funeral Service Lig	ensee	22. Name and Addr	200	2	ERAL HIM	
_	20 E # 9		( Faturia !	Dett				ning MD 3	Approximate
			shock, or heart failure. List on	implications that caused the death.  ly one cause on each line.	Do not enter the mode of dy	ing, such as cardiac o	r respiratory arrest		Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ISCHEM		10 myola	IHY.		
	Examiner			Due to (or as a consequer	100 01).	109	11800		
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequer	nce of):				
VI	ecuted and t-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.	0				
90,	ate be executed hysician and the burial-transit		resulting in deathly cast	<ul> <li>Due to (or as a consequer</li> </ul>	nce on:				
68760,	ate hys	edical		d.				1	
Box (	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	n/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of pregnanc				23d. Date of delive	
	death e atte ed for	by Physician/M	in the past 12 months? 1 ☐ Yes 2 📉 No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown		cy		Month	Day Year
P.0	at the de d by the a etached	Phys	9 Unknown		an in the conduction on the	wan in Deet I	23a Did toha	cco use contribute to t	he cause of death?
	ires tha signed I I be det	by	Pan II. Other significant condition	s contributing to death but not resulti	ng in the underlying cause g	IVOI) III Faiti.		2 □ No 3 □ Prot	A.c.
Ö	w require been si should I	Completed					24a. Was an	24b. Were auto	psy findings available
Rec	he lav e has	ошо					autopsy performe	prior to co death?	mpletion of cause of
tal	Physicien: The lav this certificate has al director, page 2	a	25. Was case referred to medical			26. Place of Death	1 Yes 2 on (Check only one)	No 1∟Yes	200,110
į	ysici	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ EF	R/Outpatient 3□ DOA	ther: 4 Nursing Ho	me 5 Residen	ce 6 □Other (Specia	(y)
0 1	Attending Physicien: r death. ector: After this certifics by the funeral director, I	:uo	27. Manner of Death 1   Natural 5 □ Pending	(Month, Day Year)	8b. Time of 28c. Inj Injury W	ork?	28d. Describe how	injury occurred	
sio	uttendi death. ctor: A y the fu	icat	2 Accident investiga 3 Suicide 6 Could no	t be 280 Blood of Injury . At hom		☐Yes 2☐No	28f Location (Stre	et and Number or Run	al Route Number.
Division of Vital Records,	after of Direction by	Certification;	4 Homicide determin	building, etc. (Specify)	e, lami, street, lactory, onto		City or Town,		
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physicien: To the best of my knowl	edge, death occurred at the	time, date and place,	and due to the cau	se(s) and manner as s	tated.
	the Ho	Medical	one)	ceminer: On the basis of examinatio and manner stated.					
	To To To Con	2	29b. Signature and title of certifier	media mo		NS Number		d. Date signed (Month,	157, 2 Del
			- XVIII N	*		MDER P M		- CENTOW (	
	2			ho completed cause of death (Item 2	Α	LSTOWN		21133	
	Si	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re & spar	~ 10 CN 'Y	1110		
	Regis		DEC 09	2004 Server	to paper				

		1	For State Registrar	State of N	Maryland		artment of H			iene	4 38976
	Physicia	an	1. Decedent's Name (First, Middle,	-		_	Jone	8	2. Date of Dea Month 12	th Day 2004	ar 2;05p M
	/Medic Examin		4a. Facility Name (If not institution, 2700 Berea Rd.	give street and numbe	or)			r Location of Deat	h	4c. County of D	eath
	Funeral Director		5. Social Security Number 251–34–5404	1 □ M 2√2 F	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day 2-22		Birthplace (State or Foreign Country) S.C.
	yland Mor		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	ocation				10d. Inside City Limits
	he Mar 28a-1 st	ector	Md. NA			Balt	imore			10g. Citizen of What	1 Yes 2 No
	h with 1	al Dir	2700 Berea Roa	ıd			212	25		USA	
36	72 hours after death with the Maryland Insturat, or ttems 23s or 28s-f show disal Examinat must be twilfled at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Marrie  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force od 1  Yes  Yes, Give Year or Date:	s? □No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		Specify Yes or No- to Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. Black
'n	72	eted	15. Decedent' (Specify only highest	s Education grade completed)		(Give	dent's Usual Occup	during most of wo	rking	16b. Kind of Busine	ess/Industry
2121	ad within /giene. er than	Completed	Elementary/Secondary (0-12) 8th grade	College (1-4d	or 5+)	life.	DO NOT use retired Dieticia	in		Varie	s
Maryland	2 should be filed of and Mental Hygie is marked other aumatic event, II.	To Be	17. Father's Name (First, Middle, L Peter		Chisolm			Sara	h	Maiden Sumame)  Denn	
	2 5 mg		19a. Informant's Name/Relationsh Sarah Nobles	<sub>ip (Type, Print)</sub> Daught	er		ng Address (Street Margate			r, City or Town, Sta e, Md. 21	te, Zip Code) .060
Baltimore,	0 0 = =		20a. Method of Disposition  1		118		psition (Name of matory or other place of control of co		Date -8-04	20c. Location - City  Lansdow	
Baltir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L				Name and Addre		Balti 1101	more, Md. E. North	21202 Ave.
8760,	Attending Physicien: The law requires that the death certificate be executed ring and redath.  The death cector: After this certificate has been signed by the attending physician and properties by the funeral director, page 2 should be detached for use as the burial-transit and properties.	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or b Due to (or c	as a conseque as	ence of):	ter the mode of dyin	stn c	P.	rest,	Approximate Interval Between Onset and Death 3 Years
Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No 9   Unknown		n 2 ☐ Fetal t at time of de	death 3[	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	f delivery Day Year
ds, P.0	uires that the signed by the detact	b	Part II. Other significant condition	ns contributing to deat	h but not resu	atting in the u	underlying cause gr	ven in Part I.	23e. Did to	V	te to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	: The law require cate has been si , page 2 should b	Completed							24a. Was autop perfo 1 □ Yes	rmed? prior	e autopsy findings available r to completion of cause of th? Yes 2 \(\sumbole\) No
Vita	ysicien: Th is certificate director, pag	To Be	25. Was case referred to medical examiner?	Hospital: 1  Inp	atient 2 🗆 I	ER/Outpatie	nt 3 DOA Ott	26. Place of Dener: 4 ☐ Nursing	eath (Check only o	<i>ne)</i> dence 6 ⊡Other (	Specify)
n of	ding Phys		27. Manner of → ath  Natural 5 □ Pendin	28a. Date of l (Month,		28b. Time of Injury	Wo		28d. Scribe h	now injury occurred	
Divisio	i Dift o	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	ot be	Injury - At ho , etc. (Specify	me, farm, st	M 1	Yes 2 □ No	28f. Location (S City or Tov		or Rural Route Number,
	To the Hospitel within 24 hours of To the Funerel Completely filled	edical C	29a. Certifier Certifyin (Check only one) Certifyin	g Physician: To the be Exeminer: On the basi and manner	is of examinat	wledge, dea tion and/or in	th occurred at the tinvestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	to	V	~	29c. Licen:	D39	140	29d. Date signed (A	Joe 3 2004
l _	6		30. Name and address of person	hrww!	ACAI	DA	. Print) 300	1150	Hance	ves ?	1225
7	St Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 0 9 2		gistrar's Signal	ture	Sports	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 24a per mr 8838 12-9-04 vt. State of Maryland / Department of Health and Mental Hygien?

38977 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Mary Grace Klinedinst Spertzel /Medical December 4. 2004 9:26 AM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Yrs. Director 179-07-1588 84 PA Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits item 27 is marked other then "netural", or items 23e or 28e-f show other treumetic event, If a Madical Examiner must be notified at 1X Yes 2 No Director PA Adams Idaville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 Idaville-York Springs Rd Funeral 17337 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ð 3 Nidowed 4 Divorced Year or Dates: White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) 12 Tester permit. Pages 1 and 2 should be filed or Department of Health and Mental Hygis importent: if item 27 is marked other any injury or other treumetic event. Manufacturing Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Klinedinst Grace Slaubaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 N. St. John's Rd Daughter <u>Lois Bucher</u> Camp Hill, TA 17011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 A Removal from State 4 Donation 5 Other (Specify) Hampton Union Cemeteru Dec 7, 2004 New Oxford, PA 17350 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Mark home 0.300 Feiser Funeral Home, Inc New Oxford, PA 17350 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 0000 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** UMmo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the buria P.O. Box 68760 þe Physiclan/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 🗌 Yes 2/2\No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred of or Attending Parties distributed of the death. Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 51705 nn 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint) Mestramoles 10 m. PANSURIYA malbelm 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 9 2004 Registrar

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 38978 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Day Year 155a December 3 5004 4:30 PM /Medical 4a Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns If Under 24 Hrs 40spitah 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1,1906 Mary Land 1 □ M 2 😾 F 98 217-22-9893 Director Yrs Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location r than "naturel", or Items 23a or 28a-f show the Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ₹ No Directo Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court 21204 U.S.A. filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify. 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registrar Hospital and Mental Hygie permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John William Evans Frances Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 12912 Falls Road Cockeysville, Maryland 21030 Mrs. Joan Thompson (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 12/7/04 Cedar Hill Cemetery Brooklyn, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility
Mitchell-Wiedefeld Funeral Home Inc.
6500 York Koad Baltimore Marvland Tron 23a. Part1. Enter the disease, or complications that could the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Subdunat /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed as the burial-transit Methall. M.O. and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year signed by the at Id be detached fo 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💆 No 3 Probably 4 □Unknown Completed Deen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has autopsy performed certificate 2 **X**No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1XYes 2□No Other: 10 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? Director: After 5 Pending investigation 1 Natural 19:00PM 1 ☐ Yes 2 ☐ No 2 Accident rable Nevember 28-04 6 Could not be determined Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) within 24 hours after To the Funerel Direct 4 \( \tag{Homicide} lowson Itome 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (0 December 3,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthey mcG, 31. Date filed (Month, Day, Year) 32\_Registrar's Signature State Registrar DEC 0 9 2004

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2004 38979
	Physici /Medic	cal	1. Decedent's Name (First, Middle, Last) Roland Donald Kirk  2. Date of Death Month Day Year December 04 2004  4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death
	Examir Funeral Director	ner	8009 Windsor Mill Road Woodlawn Baltimore  5. Social Security Number 6. Sex Months Days Hours Min. (Month, Day, Year)  121.2. 10. 57/4/ 121. M. 20 F. O. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)  21.2. 10. 57/4/ 121. M. 20 F. O. Age (In yrs. last birthday) Months Days Hours Min. (Month, Day, Year)  22. 12. 13. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15
d 21215-0036	Hygiene. the Than "natural", or Items 23a or 28a-f show int, the Madical Examinating Instituted at	e Completed by Funeral Director	Usual Residence of Decedent  10a. State
Maryland	and Mental is marked o	To Be	William Columbus Kirk  Anna Elizabeth Loos  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore,	nent o		Mrs. Mildred Easter (Daughter) 3807 Byxbee Rad, Randallstown, Maryland 21133  20a. Method of Disposition    Burial 255 cremation 3   Removal from State   20b. Place of Disposition (Name of cemetery, crematory or other place)   21. Signature of Funeral Service Licensee   22. Name and Address of Facility Loring Byers Funeral Directors In 8728 Liberty Road, Randallstown, Maryland 21133  23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):
68760, ificate he executed	ng physician and as the burial-transit	Aedical Examiner	Sequentially list conditions, if any beginning to many districtions are full or formal and the f
O. Box	by the attending phystached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) Month Day Year
Records, P.O	been signed t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 22No 3 Probably 4 Unknown
		e Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No  25. Was case referred to medical 26. Place of Death (Check only one)
Vision of	Alter this	Certification: To B	examiner?    Yes   No
To the Hospital or	within 24 hours after death To the Funeral Director: completely lilled in by the	Medical C	29a. Certifier (Check only one)  20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
ŀ	V		30. Name and address of person who completed cause of death (Ham 23a) (Type, Print)  Steven Silet w 6190 Fenge from BIVR Fldersburg MN 21784
	Sta Registi	1	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  10-18-09  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  5+wm (S.11et) w, 6190 George tom (SIVR), Eldersby MN 21784  31. Date filed (Month, Day, Year)  DEC 0 9 2004  32, Registrar's Signature  Aparella

			For	State of Maryland / De	partment of Health and	•	ene
			State Registrar	C	ertificate of Death		9. NO. UU4 38980
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year
	/Medic	al	JOSEF KONFEDERAK	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or Location of Dea		R 4, 2004 12:32 A. <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give s MARINER HEALTH CA)		LAUREL	ų i	PRINCE GEORGE
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthd			
	Director		308-38-4900	M 2□F 94 Yrs	i. Month's Day's Hours will	3/10/19	10 POLÁND
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
	Mary s-f sh	tor	MD PRINCE	GEORGE LAUREL			1 Yes 2 No
	or 28	Oire	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	s 23a	rail	14200 LAUREL PARK		20707	Canada Van er No	USA  14. Race - American Indian,
	ter de	Fune	11. Marital Status  1 Never Married 2 Married	1 ☐ Yes 2 ☐ No	<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li> </ol>	rto Rican, etc.)	Black, White, etc.
Maryland 21215-0036	ral', o	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: WHITE
5-0	filed within 72 hours after death with the Maryland Hygiene. other then "natural; or Items 23a or 28a-f show ent, I'ra Ms Jisal Exatrimet rust be notified at	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade	completed) (G	ecedent's Usual Occupation live kind of work done during most of wi le. DO NOT use retired)	orking 1	6b. Kind of Business/Industry
12	withir iene. then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	ACHINIST		MACHINERY
D 2	oe filed al Hygi d other	Be C	17. Father's Name (First, Middle, Last)	<u> </u>		me (First, Middle, M	
ylar	should be and Mental marked o	ToE	UNAVAILABLE			ILABLE	
Nar	12 sho h and 7 is m reum	0	19a. Informant's Name/Relationship (Typ		ailing Address (Street and Number or F		
e,	1 and 2 Health Iem 27 other tr		KARL KONFEDERAK / 20a. Method of Disposition	20b. Place of Di	sposition (Name of		UREL, MARYLAND 20708  Oc. Location - City or Town, State
OE .	Pages ient of nt: If I		ty⊒Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State COLUMBI.	crematory or other place) A MEM. PARK 12/	13/04	COLUMBIA, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then. Instural; or Items 23a or 28a-f show entry injury or other treumatic event, Tra Madical Examinating the multipled at once.		21. Signature of Funeral Service License		OO Name and Address of English		RAL HOME, INC.
	20 E 2 A	3	rema Dow	wa	7601 SANDY SPRING	ROAD, LA	UREL, MARYLAND 20707
	210		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on immediate Cause (Final	e cause on each line.	enter the mode of dying, such as cards	ic or respiratory arre	st, Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	PNEUMONIA Due to (or as a consequence of):			
	Examiner		Sequentially list conditions	SEPSIS			
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
	be axecuted sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			
760,		cai					
68	eath certificat attending phy I for use as thi	ed	IF FEMALE:				
Вох	death certifica e attending ph ed for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	D 0 0	Physician/M	1 Yes 2 No	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		
σ	law requires that the as been signed by th 2 should be detache	by Pł	Part II. Other significant conditions con		e underlying cause given in Part I.		acco use contribute to the cause of death?
ords	w require been sig should b	ted t	CLL (CHRONIC LYMP	LOCYTIC LEUKOEMIA		1 🗆 Yes	s 2 No 3 Probably 4 Unknown
Records	e law r has be je 2 sh	ompleted	PARTIAL GASTERECT	ONY	<u> </u>	24a. Was an autopsy perform	prior to completion of cause of
alF	Th age pag	O	OS Mas area referred to medical		20 81 48	1 ☐ Yes 2	No 1 ☐ Yes 2 ☐ No
Vital	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1  Inpatient 2 ER/Outpa	Othor	eath (Check only one Home 5 - Resider	nce 6 Other (Specify)
J Of		J: L	27. Manner of Death 1 ▼ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at	28d. Describe how	
sioi	a ta : 0	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	000 1	2 - 1 2 - 1 4 - 1 - 1
Division	or Attent after death Director:	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	City or Town,	eet and Number or Rural Route Number, State)
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th		29a. Certifier Certifying Phys	sicien: To the best of my knowledge, o	leath occurred at the time, date and place	e, and due to the ca	use(s) and manner as stated.
	the Ho hin 24 the Fu npletel	Medical	опе)	and manner stated.	or investigation, in my opinion, death oc		
	With To	2	29b. Signature and title of certifier	n Attendrus	29c. License number	29	d. Date signed (Month, Day, Year)
,			30. Name and address of person who co	0	D42580		12/8/2004
	`		PARMJIT SINGH AUJ			BLADENSBU	RG, MARYLAND 20710
	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 9 2004	32. Registrar's Signature	Sparks		N.

State of Maryland / Department of Health and Mental Hygien [ ] ] [ 38981 1- State Registramend ITEM #10d PER FH G838 12709704 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DEC. Day 6 **Physician** 2004 2:35 AM ROSE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE PIKESVILLE BRIGHTON GARDENS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 05/001/P1/905 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 VA **Funeral** 1 □ M 2 K F 95 216-05-5386 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at XXes ZNO Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò U.S.A. 6711 PARK HEIGHTS AVENUE, APT. 21215 or items 23a 307 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Black, White 1 ☐ Never Married 2 ☐ Married WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 X Widowed 4 ☐ Divorced natural', leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Compl Elementary/Secondary (0-12) 12 College (1-4or 5+) CLOTHING STORE **PROPRIETOR** 12 should be filed wind and Mental Hygien 7 is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LAND HERMAN NETTIE BENJAMIN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum. once. 3 PINE SPRING LANE OWINGS MILLS MD 21117 BERNARD KRIEGER / SON 20a. Method of Disposition

1 \( \Delta \) Burial 2 \( \Delta \) Cremation 3 \( \Delta \) Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BETH EL MEMORIAL PARK 12/08/2004 RANDALLSTOWN, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 West 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one hause on each line. Approximate Interval Between Onset and Death THEROSCLEROSIL Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): physician Box 68760. Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) p.0. by the stached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by HGARI ONGESTIVE 1 Yes 2 No 3 Probably 4 Unknown Completed EPERTION. 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence & Dother (Specify) IVING Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Fungral Director: After the Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sullu Name and address of person ocompleted cause of death (Item 23a) Tipe, Print) ANE IMENERM 7220 31. Date filed (Month, Day, Year)
DEC 0 9 2004 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryl		artment of H			ene2004	38982
Ī	Physici		Decedent's Name (First, Middle, La MIKA	-	OWERY			2. Date of Death		3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, given Univ. of Mar	yland Medic	cal Sys	4b. City, Town, or Balt:	Location of Death		4c. County of Dea	ath
	Funeral Director			Sex 7. Age (In )	yrs. last birthday) Yrs.	If Under 1 Year Months Days 07 16	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign Country)
	and **		Usual Residence of Decedent  10a, State 10b, County	10c.	. City, Town or La	ocation				10d. Inside City Limits
	Maryl f sho	tor	MD Prince	Georges Ca	nital	Heights				1 □Yes 2 No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number	ocorges  co	prear	10f. Zip Code		10	g. Citizen of What C	country?
	23a c		6902 Sea Plea	sant Drive			743		U.S.A	•
	er des Items	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
213-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "naturel", or Items 23a or 28a-f show event, the Medical Examinat mat be nutified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give   Year or Dates:		1 □ Yes <b>X</b> No	Specify:		Specify:	Black
ה	n 72 h "natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of work	sing 1	6b. Kind of Business	s/Industry
7 1 7	i within jiene. r than "	omp	Elementary/Secondary (0-12) N/A	College (1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	N/A	,		N/A	
ana	e filed al Hygie I other vent, II	Be C	17. Father's Name (First, Middle, Last			N/A	18. Mother's Nam	e (First, Middle, M		
ylai			Michael Smith				Sandra	Lowery		
Mar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship						City or Town, State,	Zip Code) 20743
e,	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		Michael Smith-  20a. Method of Disposition		<ul> <li>b. Place of Dispo</li> </ul>	Sea Ple			Capital Oc. Location - City o	Heights, Mo
ē	Pages ent of nt: If i		Murial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		•	matory or other place	. !	12/5/6	)/ Class	on CO., SC
Baltimor	permit. Pages. Department of I Importent: If ite any injury or of		21. Signatur of Funeral Service Lice	7500	M.	2. Name and Address arch F/F	is of Facility	1 12/0/(	74 Clara	on co., sc
מ	89 5 8		> XUMUUU I	) Jugut	4.	300 Waba	ash Ave		more, Md	21215
			23a. Part1. Enter the disease, or composition of the control of th	one cause on each line.			g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Opset and Death
	Physician /Medical		Immediate Cause (Final disease or condition esulting in death)	Acute Re		ilure				48 Hours
	Examiner		Securetially list and divine	Due to (or as a con Broncho	pulmona	ry Dysp	lasia			7 months
1	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-		-				4 Months
	al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con:						
8/60,	that the death certificate be executed ed by the attending physician and detached for use as the burial transit	dical E	(	Severe	Acid Ba	se Imba	lance			48 Hours
٥	ing ph	Med	IF FEMALE:							
nox	death ce	ician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	Ectopic pregnancy			23d. Date of de Month	olivery Day Year
j.	the de	hysic	1 Yes 2 No 9 Unknown	4☐Pregnant at time of the second sec	ordeath 5L	Other (specify)				
າ ໂ	s that the ined by the e detache	by Pł	Part II. Dther significant conditions	contributing to death but not	resulting in the u	nderlying cause give	on in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
cord	w requires that been signed be should be det							1 🗆 Yes	2 X No 3 □ P	robably 4 Unknown
Heco	e la has	ompieted						24a. Was an autopsy	24b. Were a prior to death?	utopsy findings available completion of cause of
vital	ilcien: The l certificate ha rector, page	e Co	25. Was case referred to medical				00 Disease ( Dasse)	performe		s 21 No
	S O D	0 B	examiner?	Hospital:	2 ☐ ER/Outpatien	it 3□ DOA Othe		h <i>(Check only one,</i> ome 5 □ Residen	ce 6 □Other (Spe	ecify)
n 0T		on: T	27. Manner of Death 1 Phatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year		28c. Injury Work	at :?	28d. Describe how		,
<u>0</u>	Attending ir death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be	n		M 1 1	res 2 □No			
DIVISION	<u> </u>	ertification:	4 Homicide determined		At home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospitel of within 24 hours aff To the Funerel Discompletely filled in	edicai C	29a. Certifier  (Check only one)  Certifying Place   2   Medicel Execution	nysicien: To the best of my miner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1-17		29c. License P177			Date signed (Mon	
			Kilheras	relise	mi					
	1		30. Name and address of person who Richard R. Tel	completed cause of death ( esco, MD 22	Item 23a) (Type, S. Gr	<sup>Print)</sup> eene St,	Baltin	nore, Md	21201	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si		,				
	Registr	ar	DEC 0 9 20	104 Janes	2 19	Sports	T.A.			

		•	For Stete Registrer	State of N	Maryland		artment tificate			ind Me		giena Reg. No	004	38983
	Physicia	an	1. Decedent's Name (First, Middle, Last, MARY B • LUCA								2. Date of Dea	Day	Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		r)		4b. City, T	Fown, or	Location of	f Death	104	4c.	County of De	ath
	LAGITIII		UNION mEMORIAL	HOSPITA	AL		В	ALT	IMOR					
	Funeral Director		100-24-4000	7. A	Age (In yrs. la 75	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 12-12	h у, <i>Year)</i> -19	9. B 9. 28 MA	irthplace (State or Foreign Country) RYLAND
	lend ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary Fied	tor	MD			BALT	IMOR	E						1 Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip		_				izen of What	Country?
	seth w	erai	3801 CANTERBURY	RD 12. Was Deceder	at Ever in LLS	S 12 1		121		nin2 /Sna	cify Yes or No	US		nerican Indian.
<b>'</b> O	s 1 and 2 should be filed within 72 hours after deeth with the Marylend if Health and Mental Hygiene. Item 27 le marked other then "natural", or items 23e or 28e-f show other treumatic event, the Medical Event and must be rivilled at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 2	s?	1	f Yes, spec	ify Cubar	n, Mexican,	, Puerto F	Rican, etc.)		Black, Wi	
03	ours a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates	B:		1 ☐ Yes 2	No No	Specify:				Specify: W	HITE
21215-0036	n 72 h "natu edice	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		(Give	dent's Usual kind of wor DO NOT us	k done d	uring most	of workin	g		ind of Busines ${ m TERIO}$	•
212	d within 72 piene. r then "nat	ошо	Elementary/Secondary (0-12) 12YRS	College (1-4o	r 5+)		RIOR			TOR			CRATI	
	be filed vital Hygie od other fevent,	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
yla	should to the marked umatic e	P_	JOHN EDWARD JO			401-14-75		(0)			MANI		T	7.0.1
Maryland	d 2 shoth and the and the m		19a. Informant's Name/Relationship (T)  LAWRENCE K. WHI		)		•	•					or Town, State	
di.	s 1 an f Heal Item 3		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nam	e of			ate		ocation - City	
<u>i</u>	Page nent c ent: If ury or		1 ☐ Burial 2 X Cremation 3 ☐ F  1 ☐ Donation 5 ☐ Other (Specify)		( <del>0</del>	-	-		.	RY12	2/9/20	04	BALTO	. CITY, MD.
Baltimore,	permit, Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signature of Funeral Service Licens	with		H	Name and ENRY	W.	JEN	KINS	& SONKTON	NS	CO.	1 1
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caus ne cause on each	ed the death	. Do not ent	er the mode	of dying	, such as	cardiac or	respiratory ar	rest,	• 211	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	ebeli		Her	nov	YMO	96				Onsel and Death
	/Medical Examiner			Due to (or a	as a consequ	ience of):	lence	()		V				14 hauss
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequ	ience of):	0/0/	LI						14/201/5
レバ	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequ	agul	o pu	My	/					17/1000
68760,	ite be executed iysician and he burial-transit	cai E		Due 10 (01 e	as a consequ	ionico-on).	•							
39	± > 0			o,										
Вох	death certifical e attending phy od for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 - Fetal	death 3	Ectopic pre	egnancy					23d. Date of o	lelivery Day Year
o.	0 0 2	yslci	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eath 5	Other (spe	ecify)					Wichian	Day I dai
٩	The law requires that the de ste has been signed by the a page 2 should be detached		Part II. Other significant conditions co	ntributing to death	but not resu	ılting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco u	use contribute	to the cause of death?
rds,	w requires been sign should be	ed by									1 🗆 1	(es 2	No 3□	Probably 4 Unknown
Vital Record	e taw re has bed je 2 sho	Completed									24a. Was	sy	prior t	autopsy findings available completion of cause of
E R		Con										rmed? 2 No	death	
Vita	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	stiont of te	Outnotion	2 7 70	Othe	16.		(Check only o		6 ☐Other (S <sub>I</sub>	
of		$\vdash$	27. Manner of Death	28a. Date of Ir	-	Outpatier 28b. Time o Injury		Bc. Injury Work			8d. Describe			весту)
ion	E - \$ 2	atio	1 Natural 5 Pending 2 Accident investigation	(MONTH, E	Jay ( Gai)	mjury	М		es 2□h	No				
Division	after death after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building,	Injury - At hor etc. (Specify	me, farm, str	eet, factory,	, office		2	8f. Location (S City or Tov			Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in b	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sicien: To the be ner: On the basis and manner	of examinat	wledge, deat ion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s) date and	) and manner d place, and d	as stated. ue to the cause(s)
•	To the within 2. To the complet	Me	29b. Signature and title of certifier	Kash	y y A		1	) Ol	15211	103		j -	1/2/	nth, Day, Year)
•			30. Name and address of person who	ompleted cause o	f death (Item	23а) Дуре	Print)		- //				-/ 0/	500
_	12		Union 17	removed	Ho.	50.14	N	Ville	am	F	rohn	α,	MD	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 9 2	004 32. Reg	trar's Signat	ture	4	cord	21		rohn			

Baltimore, Maryland 21215-0036

		1 - For State Registrar	State of Man		epartment of C <i>ertificate of</i>		Mental Hygier	/	38984
Physici	an	1. Decedent's Name (First, Middle, L					2. Date of Death	Day Year	3. Time of Death
/Media	cal	IRENE	R.	•		VIN	December	5 200	
Examir	ner	4a. Facility Name (If not institution, g	l of Balt	imore		or Location of Deat	City !	4c. County of Dea	
Funeral			Sex 7. Age (1.	n yrs. last birth		If Under 24 Hrs	8. Date of Birth	9. Bir	N/A thplace (State or Foreign
Director		215-10-6571	1 M 2 K F	86 Y	rs. World's Days	Hours Will.	8. Date of Birth (Month, Day, Yea FEB. 28, 1	918	MD
/land		Usuel Residence of Decedent  10a. State 10b. County	10	oc. City, Town	or Location				10d. Inside City Limits
a-fsh	ctor	MD E	BALTIMORE			BALTIMOF	RE		1 □Yes 2 No
or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What C	ountry?
sath w	erai	6527 GARDENWICK	ROAD  12. Was Decedent Eve	211011	12 Mas Deceded of	21209	See at Ven and	14 Dans Am	USA
ritem	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 No	ir in U.S.	<ol> <li>Was Decedent of If Yes, specify Cut</li> </ol>		to Rican, etc.)	14. Race - Am- Black, Whi	
ral', o	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE
"natu	ietec	15. Decedent's (Specify only highest of	Education irade completed)	(	Decedent's Usual Occu Give kind of work done	during most of wo	rking 16b.	Kind of Business	/Industry
within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life.  DO NOT use retire EMAKER	<del>3</del> 0)	01	WN HOME	
al Hyg othar vant,	BeC	17. Father's Name (First, Middle, La.	st)	1.2,2.2.2		18. Mother's Na	me (First, Middle, Maid		
should be filed within /2 hours atter death with the Maryland nod Mental Hygiene. In advers! or items 23a or 28a-f show in marked othar than "natural" or items 23a or 28a-f show umatic evant, it a Medical Evanticartinas to indiffed all	Tof	HYMAN		-	RNICK	MINNI			KOLODNER
and 2 sh ealth and m 27 is m nar traum		19a. Informant's Name/Relationship		1.			ural Route Number, City		
Heali Heali tem 2 othar		DONALD LEVIN / S  20a. Method of Disposition	SON	20b. Place of D	02 SUGARCO		BALTIMORE Date 20c.	Location - City or	
Pages nent of I nnt: If it		1 X Burial 2 □ Cremation 3  1 4 □ Donation _ 5 □ Other (Spec	☐Removal from State		crematory or other pla ACOB CEMETI		7/2004	FINKSBUR	G. MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By any injury or other traumatic evant, If a Medical Evant institutative undiffed at Once.		21. Signatur Juner V Service V	ensee		22. Name and Addr		L LEVINSON		
205 g g		Munde	Muga	1 1 2	8900 REIS	TERSTOWN	ROAD - PIK	ESVILLE,	
		23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	by one cause on each line.	death. Do no	t enter the mode of dy	ing, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	onsequence of	)·				
Examiner		Sequentially list conditions	b	,	,				
pe tis	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of	):				
xecuted and al-transii	Ехап	that initiated events resulting in death) Last	c Due to (or as a co	onsequence of	);				
icate be executed physician and s the burial-transit	edicai E		d						
ing ph	Medi	IF FEMALE:		-					
ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death	3 ☐ Ectopic pregnanc	:y		23d. Date of de Month	livery Day Year
y the d	nysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tim 9□Unknown	e or death	5 ☐ Other (specify) _				,
w requires that the death certific been signed by the attending p should be detached for use as	by Pt	Part II. Other significant conditions			he underlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
equire sen sig ould b	ted t	Congestive	Heart Fa	elure			1 ☐ Yes	2 □ No 3 □ Pi	obabiy 4 Dunknown
aw r as be b 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
s certificate has birector, page 2 s							performed?	death?	2 No
ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	2 ER/Outp	atient 3 DOA Ot	her	ath (Check only one)  Iome 5  Residence	6 Mother (See	a/6.1
ding Phy h. After this funeral c		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Tin	ne of 28c. Inju	ry at	28d. Describe how in	<del></del>	Cuy)
	catic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on			Yes 2□No			
tands leath. tor: A the fu	=	4 Homicide determine			n, street, factory, office		28f. Location (Street a City or Town, Sta		ıral Route Number,
or Attandis after death. Director: A in by the fu	erti			5,000.197					
ospital or Attandion nours after death. Inaral Director: A filled in by the fu	ai Certification;	29a. Certifier 1 ☑ Certifying F	Physician: To the best of m	v knowledge.	death occurred at the ti	me, date and place	, and due to the cause	s) and manner as	stated.
ne Hospital of Attants in 24 hours after death. tha Funaral Director: A pletely filled in by the fu			Physician: To the best of maminer: On the basis of examiner stated	y knowledge, o	death occurred at the ti or investigation, in my (	ime, date and place opinion, death occu	l , and due to the cause( irred at the time, date a	s) and manner as nd place, and due	s stated. to the cause(s)
To the trospital or Attanding Prystician: The law requires that the death certificate be exe within 24 hours after death.  To tha Furnarial Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial-	Medical Certi	(Check only 2 Medical Example)  29b. Signature and title of certifier	aminer: On the basis of exa	y knowledge, o	or investigation, in my	opinion, death occu	rred at the time, date a	nd place, and due late signed (Mont	to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

HOSPITAL

OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAZI A. ZAMAN, M.D. SINAI

31. Date filed (Month DEC 0 9 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 38985 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MCINTYRE KATHERINIE 9-40 Pm DECEMBER 1 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner '000 SAMARITAN HOSPITAL 7. Age (In yrs. last birthday)

1. Months Days Hours Min.

1. Age (In yrs. last birthday)

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1. Age (In yrs. last birthday) BALTIMORE 6. Sex Birthplace (State or Foreign Country)
 D. **Funeral** 24 8862 1 □ M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Exeminer roust be notified at Director 1 Yes 2 □ No Bathmore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11.5.2 'natural', or itams 23a 6/00 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Seines Food BEANTES Pages 1 and 2 should be filed vent of Health and Mental Hygies int: If item 27 is markad othar t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edith HARRIS SEINERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or othar trau HAROLD 6100 EVERAI AUE AN 201 BAITMON MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State JOKEST 4 ☐ Donation 5 ☐ Other (Specify) GARRISON BAHMONINO 21. Signature of Funeral Service Licensee BEHS Funeral Home Sotrer Berl Bostomere, MD 1129 N. CARUTINE St 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): GRAFT IMFECTION Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Dinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STAGE REMAZ 2 No 3 Probably 4 Unknown 1 🗌 Yes ADRIC PLAQUES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HEMATURIA

25. Was case referred to medical examiner?

Hospital: Hospital or Attanding Physician: 26. Place of Death (Check only one) Hospital: 1 patient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year) 28b. Time of Injury Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 6 ☐Other (Specify) 27. Manner of Death 1. XNatural 2 ☐ Accident 28d. Describe how injury occurred Certification: 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) To tha h 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 1 2004 ess of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEM BLUD 32. Registrar's Signature Registrar

			State of Maryland / Dep.		•	0001	
				rtificate of Death	Reg. N	2004	38986
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Mongonat C M Mongo			ay Year	3. Time of Death
	/Medic		Margaret C. M. Marsh  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	December 7	7, 2004 c. County of Deat	2:00 P <sup>M</sup>
	Examin	er	Ellicott City Health & Rehabilitation			Howard	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	7			hplace (State or Foreign untry)
	Director		362-26-5504 <sup>1□M 2</sup> ♥F 84 Yrs.	Mortals Says Hours Italia.	8. Date of Birth (Month, Day, Year SEP 19, 19	920 Ne	braska
	land At		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lit	ocation			10d. Inside City Limits
	Mary	tor	Maryland Howard	Ellicott City			1 ☐ Yes 2 X No
	or 28s	Funeral Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Co	untry?
	ath wi	ral	3000 N. Ridge Road	21043		USA	
	er deg	nne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	<ol> <li>Race - Ame Black, White</li> </ol>	
5	urs aft	by	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: W	nite
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V	filed v Hygie ther t		12 Home	emaker	e (First, Middle, Maide	Own Home	
2	id be ental ked o	To Be	Edward McGuire		Mary Step		
ă	2 should be filed within 72 hours after death with the Maryland and Menhall Hygene. and Menhall Hygene. Is marked other than "natural", or Items 23a or 28a-f ehow aumatic event, It a Medical Evacular invastice redifficat	_	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Run	al Route Number, City	or Town, State, Z	Tip Code)
., E	and 2 ealth ar n 27 is				umbia, MD		
2	Pages 1 nent of Hi ant: If iter ary or oth		1 🗆 Buriai 2 📉 Cremation 3 🗀 Hemoval from State	osition (Name of matory or other place)	Date 20c. L	ocation - City or	Town, State
Dalliiio			'4 □ Donation 5 □ Other (Specify) Metro Cr  21. Signature of Funeral Service Licensee	ematory, Inc. 12/8	3/04	<u>Baltimor</u>	e, MD
O O	permit. Departr Imports any inj		Edward A. Gregorchik 2	2. Name and Address of Facility Cremation Society ( 199 Frederick Road	of MD, Inc.	MD 212	20
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	, FID 212	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ONIA			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		-i	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events				
,00,	e exection and an and and and and and and and and	Exa	resulting in death) Last  Due to (or as a consequence of):				
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ă	death e atter	Iciar	in the past 12 menths?  1 Ves 2 No.  4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
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Ď,	signed	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	1 Yes 2		the cause of death?
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ב ב	he lav e has age 2	Completed			autopsy performed?	prior to death?	topsy findings available ompletion of cause of
פ	ilcian: Th certificete rector, pag	0	25. Was case referred to medical	26. Place of Death	1 Yes 2 No	1 Tyes	2□ No
5	Physical this cer al direc	To B	examiner?  1   Yes   2   No	nt 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 Other (Spec	ify)
5	ding Physician: The In. After this certificate he funeral director, page	on:	27. Manyer of Death 1 ▼Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how inju	iry occurred	
7 2 2	r Attend er death rector: , by the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined determined	M 1 Yes 2 No	28f. Location (Street a	nd Number or Ru	al Route Number
2	al or A s after I Dire d in b	Certification:	4 Homicide determined building, etc. (Specify)	out, radialy, office	City or Town, Stat	θ)	arriode vombor,
	To the Hospital or Attending Physician: whithis 24 hours after deals after deals To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place,	and due to the cause(s	and manner as	stated.
	the H hin 24 the F mplete	Medical	and manner stated.				
	5. <u>₹</u> 5 8	_	1 4	29c. License number		ate signed (Month	
/	1 AX		30. Name and address of person who completed cause of death (Item 23a) (Type, TASNEEM AKHAMI, 7220 FA	Prijnt)	Dece	ember 8,	2004
	7(17)			KK HEIGHTS F	TE BAC	70 Mil	24208
	Sta Registr		31. Date filed (Month, Day, Year)  BEC 0 9 2004  32. Registrar's Signature	Sparks	•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1.8 per fh e838 12-14-04 vt. State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Reg. NE U O Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** George R. Manning 2004 8:31 P M Dec /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 8. Date of Birth 19:52 1**X** M 2□ F Months Days Hours Min 218-58-5122 52 Vrs Director Aug 2, <del>1954</del> Kansas Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10a, State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Modical Event are must be recified at 1 ☐ Yes 2√2 No Directo Maryland Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 817 South Camp Meade Road 21090 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1970 If Yes, Give Year or Dates: 1974 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic event, the Medical Examples 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 1974 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Corrections Officer State Of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Manning Dorothy L. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 21790 Dundalk, Maryland 21222 Joyce Steadman, Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 12/08/04 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Literature
Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KENA Physician EARS /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner and law requires that the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Š signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 1 Yes 213 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 Rother (Specify)  $\square$  1  $\square$  1  $\square$  Ce Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No 2 Director: After the 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the ! 29c. License number 29b. Signature and title of certify 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNINGTON fISH & 141CHARD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

	1 _ For		aryland / Dep	artment of I		lental Hyg	iene	
	Registrar  1. Decedent's Name (First, Middle,	(ast)	Ce	rtificate of	Death	2. Date of Deat	eg. No 2 U U	
Physician						Month	Day Yes	
/Medical Examiner	4a. Facility Name (If not institution,			4b. City. Town. o	or Location of Death	Novembe	4c. County of De	
	Gilchrist			Towson			Baltime	
Funeral			e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	0.5	hirthplace (State or Foreign Country)
Director	219-28-0758	1 <b>∑</b> M 2□F	72 Yrs.	Monais Days	Tiours IVIIII.	Jan 2,	1932 Ma	ryland
A TH	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
marked other than "natural", or items 23a or 28a-f show imatic avant, the Medical Exercited count by modified at To Be Completed by Funeral Director	MD Baltim	ore	Tow	son				1 ☐ Yes 2√2 No
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ar, or items 23s	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto f	cify Yes or No-	14. Race - An Black, Wr	nerican Indian,
V F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	10	1□Yes 2XINo	Specify:		Specify: W	
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Tof	Clifford Cla	rence Merk1	e		Ruth	Bliss S	Scott	
omer traumatic	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	g Address (Street	and Number or Rural	Route Number,	City or Town, State,	Zip Code)
3 <u>5</u>	Donna J. Bailey	/daughter			ad Baltimo	ore, MD	21227	
any injury or oth	20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac	Da	ate 2	20c. Location - City o	r Town, State
d land	` 4 X Donation 5 ☐ Other (Spe	cify)			İ			
Iny in	21. Signature of Euroral Service Lic Ronald, S	Wade Dire	ctor St	. Name and Addre	ss of Facility Omv Board	655 W.	Raltimore	Stroot
	220 2001 5000 0000	/ Wedel			omy Board MD 21201			Deleer
	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lin	e.	er the mode of dyin	g, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death
an cal	disease or condition resulting in death)	a meta	STATE	CAVein	prop	cirkne	rem	mant 6
ner		Due to (or as a	a consequence of):		progn	my Sit	le	
e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of).					
al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							1
Exa	resulting in death) Last	Due to (or as a	consequence of):					
ica		d						
Physician/Medic	IF FEMALE:						110	
cian/Medica	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	Fetal death 3	Ectopic pregnancy			23d. Date of de	*
sic	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death 5	Other (specify)			Month	Day Year
Phy	Part II. Other significant conditions	contributing to death bu	t not reculting in the wa	dashina sawa	a ia Baat	00. 014.		
1 by		eu kemi		derlying cause give	nın Parti.	_	*-	o the cause of death?
leted by Physic		00 100000				1 Tes	2 2 No 3 P	robably 4 Unknown
To Be Completed						24a. Was an autopsy performe		utopsy findings available completion of cause of
ပိ	Of Was seen referred to the first						Yes 1 ☐ Yes	2 □ No
o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:		Othe	26. Place of Death (			
i, T	27. Manner of D. ath	1 Inpatier		3☐ DOA 28c. Injury	4 Nursing Home	9 5 ☐ Residen	ce 6 X Other (Spe r injury occurred	city) Hospice
tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day	Year) tnjury	Work	? 'es 2 □ No	o. Describe now	injury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 289. Place of Injui	y - At home, farm, stre			f. Location (Stre	et and Number or R	ural Route Number
Cert	4 I Homedo	building, etc.	(Specify)			City or Town,	State)	,
cal (	29a. Certifier 1 Certifying F	Physician: To the best of	my knowledge, death	occurred at the tim	e, date and place, an	d due to the cau	se(s) and manner as	s stated.
Compretely filled in by the Tuneral Medical Certification: 1		eminer: On the basis of and manner state	ed.			at the time, date	e and place, and due	to the cause(s)
3	29b. Signature and title of certifier	1 1.17		29c. License		_	d. Date signed (Mont	
	1 / Ihrs	hy the	y, ms	1123	205	16	ecenbe	1,200 4
	30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, P	rint) 6601 N 4	Tharles C+			
State	30. Name and address of person who	2 7.	ath Item 23a) (Type, P	6601 N. (	Charles St			

DHMH 17 Rev 1/2001

_			For State Registrar		State	of Ma	ıryland / [	Depa <i>Cer</i>	artment of H	lealth and I Death		giene 0	04	38989
	Physic	ian	Decedent's Name (F								2. Date of De Month	Day	Yeer	3. Time of Death
	/Medi	cal	Donald  4a. Facility Name (If no	Robert					4. 00 -			er 29,	2004	11:44 PM
	Exami	ner	Gilchr		re street and r	iumber)			Towson	r Location of Death	1	4c. County		
	Funeral		5. Social Security Numb		Sex	7. Age	(In yrs. last bir	thday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		timor	
pm	Director		545-40-649	_	1 <b>∑</b> M 2□F		86	Yrs.	Months Days	Hours Min.	Oct 27	y, Year) • 1918		place (State or Foreign ntry) ada
27	and		Usual Residence of Dec 10a. State 10	b. County			10c. City, Town	n or Lo	cation				1.	104 Inside Obstations
1/6	/ Maryl f sho	ğ		Baltimo	re		,,		wson					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
27	death with the Maryland ms 23e or 28e-f show	Director	10e. Street and Number	r					10f. Zip Code			10g. Citizen of	What Cou	
2	th with	aiD	6601 N. C	harles	Street	t				21204			SA	•
5	er death with the Marylar Items 23e or 28e-f show	Funeral	11. Marital Status		12. Was De Armed I	Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Si	pecify Yes or No o Rican, etc.)	14. Rad		can Indian,
2	rs afte	by Fi	1 Never Married 3 Widowed 4	_	1 XYes If Yes, 0 Year or	2 □ No Sive	。 <b>'</b> 39 <b>-</b> 45	1	☐Yes 2X No		,,	Specif		hite
20 5	within 72 hours after ene. then "netural", or Ite		15.	. Decedent's E	ducation			Deced	ent's Usual Occupa	ation		16b. Kind of B	usiness/In	dustry
100	thin 7 e wed	Completed	(Specify of Elementary/Secondary	only highest gra ry (0-12)		(1-4or 5+		(Give I	kind of work done of OO NOT use retired	durina most of won	king			addity
7 5	filed wi Hygien other th	Con	8		0		<u> </u>		lab tec	chnician		dai		
	tal H	Be	17. Father's Name (Firs							18. Mother's Nam		Maiden Suman	7e)	
- Robert	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other then "netural", or Items 23e or 28e-f show other treumetic event, The Medical Evand not install be indifficed at	2	19a. Informant's Name				19h	Mailin	g Address (Street a	Grace P		. Cit Town	04-4- 77-	0.4
Š	and 2 sealth ar n 27 is		Donald Moy				130.		W. Bel				State, Zip 21001	Code)
Sonald imore M	of Hear item item		20a. Method of Disposit	tion		Α	20b. Place of	Dispos	sition (Name of place		Date	20c. Location		own, State
Ş i	Page ment ( ent: If ury or	l .	1 ☐ Burial 2 ☐ Ci	Other (Specif	y)	m State		y, o. <b>o</b>	atory or oursel place	!				
Dovalo	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumetic event, IT. M. ODG.		21. Signature of Funera	Invice Licer	Wade	Live	ctor	St Ba	Name and Address ate Anato	omy Board MD 2120	1 655 W.	Baltim	ore S	treet .
			23a. Part1. Enter the di shock, or heart fai	isease, or com ilure. List only	plications that one cause on	caused t	he death. Do n					rest,		Approximate Interval Between
	Physician		Immediaté Cause (Fina disease or condition	ıl	a		Dro	57	rate (	Ancek	2			Onset and Death
	/Medical Examiner		resulting in death)		Due to	o (or as a	consequence o	of):						1
	¥	er	Sequentially list condition if any, leading to immediate	ons, diate	b. Due to	o (or as a	consequence o	of):						
	cuted id ansit	Examiner	if any, leading to immed cause. Enter Underlyin Cause (Disease or injur that initiated events	g y	6									
Ö	be executed sician and burial-transit		resulting in death) Last	- 1	Due to	o (or as a	consequence o	of):						
8760.	cate be chysici the bu	dical			d									
9	eath certific attending p for use as	/Me	IF FEMALE:		23c. If yes, o	utcome o	f oregnancy							
Box	atten after u	clan	23b. Was decedent pre in the past 12 mon	nths?	1 🗀 Live	birth 2	Fetal death		Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive nth	ry Day Year
P.O.	that the de	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unk				Cirior (apociny)					
ν.	res tha igned l	Completed by Physiclan/Me	Part II. Other significan	t conditions c	ontributing to	death but	not resulting in	the un	derlying cause give	n in Part I.	23e. Did to	bacco use conti	ibute to th	e cause of death?
oro	w requir been si should	eted									1 U Y	es 2127No	3 Prob	ably 4 Unknown
Sec.	has by	шpl									24a. Was a autop: perfor.		Vere autop	osy findings available npletion of cause of
<u></u>	i <b>cien</b> : Th certificate rector, pag		25. Was case referred to	o modinal				_			1 ☐ Yes	210 No 1	Yes	2 No
5	ysicien: The is certificate hadirector, page	To Be	examiner?	-	Hospital:	Inpatient	2 ER/Out	nationt	3 □ DOA Othe	26. Place of Deat	h <i>(Ch</i> eck only or ome 5 ☐ Reside		- /0: "	
0	ding Phy J. After thi funeral	n: I	27. Manner of Death		28a. Date (Mo			·	28c. Injury Work		28d. Describe h			Hospice
<u>0</u>	uttending Ph death. ctor: After th y the funeral	catic	2 Accident	Pending investigation	1	, ==,		i u i y		es 2□No				
Division of Vital Records.	ol or Attenct after death Director: d in by the f	Certification;	3 Suicide 6	Could not be determined	28e. Plac	e of Injur	y - At home, far (Specify)	m, stre	et, factory, office		28f. Location (Si City or Town	reet and Number, State)	er or Rural	Route Number,
	spitel ours a nerel (	Ce	29a. Certifier 1	Certifying Ph	veician: To th	a heet of	my knowledge	death	occurred at the time					
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	(Check only 2 one)	Medical Exem	miler: On the l	basis of e	ixamination and	Vor inve	estigation, in my opi	inion, death occur	red at the time, d	ause(s) and mai ate and place, a	nner as sta ind due to	ated. the cause(s)
	To T To 1	Σ	29b. Signature and ville	of certifier	1	0		)	D25			9d. Date signed		
			71/1	with	y 16	7	· cuy			207	1	VOURn	trer	30,200%
			30. Name and address of	2 ( e	completed cau	se of dea			r <sub>int)</sub> 1 N.Charl	les Stree	et Bal	timore,	MD.	21204
	₅ Sta	te	31. Date filed (Month, Da	ay, Year)			s Signature							
	Registr	ar	DEC	0 8 200	A Re	Reco .	K	ha	K)					

	State Registrar  1. Decedent's Name (Fin	iest Middle La	State o		Cert	ificate of	Death	1	Reg. No	004	3899
ian cal	Muhammad 44. Facility Name (If not		Abdu			Munta 4b. Çity, Town, o	qim	2. Date of Month	ber 4	200 4	3. Time of Death
	Moryand 5. Social Security Number	Gene	ralh	OSpital 7. Age (In yrs. I	ast birthday)	Raltir If Under 1 Year	NOTE (1	tu/			
	249-84-49 Usual Residence of Dec	938	<b>K</b> XM 2□F	59		Months Days	Hours M	n. <i>(Month</i> , 08	Birth Day, Year) 03 4!	Co	thplace (State or Fore buntry) SC
Funeral Director	10a. State 10b	o. County			Town or Local						10d. Inside City Lim
2 2	10e. Street and Number				CIMOL	10f. Zip Code			10g. Citize	en of What Co	ountry?
by runcia	1411 Divis  11. Marital Status  1 Never Married  3 Widowed 4	2X Married	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv	2 <b>X</b> No ∕e	lf.	as Decedent of H Yes, specify Cuba	1217 lispanic Origin? an, Mexican, Pue Specify:	Specify Yes or into Rican, etc.)		U.S.F. 4. Race - Ame Black, White Specify:	nican Indian, e, etc.
Completed	15. (Specify or	Decedent's E	ade completed)		16a. Decede (Give ki	nt's Usual Occup nd of work done of NOT use retired	ation during most of w	orking		d of Business/	Black Industry
	Elementary/Secondary  L2th grade  17. Father's Name (First,	9	College (1 na	-4or 5+)		ntrepre	eneur	-		Retail	
0	Joseph Pe	eebles	3			Address (Street a	orothy	ame (First, Mid 7 R <b>ich</b> i	man		
	23a. Pa 1. Enter the dis shick, or heart mil	sease, or com ure. List only	plications that ca	aus ihe death.	43	rch F/F	sh Ave	, Balt	timore	bM ,s	21215
ai CXalliner	disease or condition resulting in death)  Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, late	b. Bue to (c) Due to (d) Due to (d)  23c. If yes, outc	or as a conseque OCATA  or as a conseque OCATA  or as a conseque	ance of):  Car  ance of):  Car  ance of):	cinome cer nfarc	a of	CO 10 Y	y arrest,	d. Date of deliv	Approximate Interval Between Onset and Death
Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list condition and it is any, leading to immediause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent preg in the past 12 mont!  1 Yes 2 No 9 Unknown	inant hs?	a. Due to (c. Due to (d. Due to (	or as a consequence of pregnant at time of dearwn	ence of):  Cy death 3   Ec th 5   O	CINOMA CCINOMA CCINOMA MFGIVA etopic pregnancy ther (specify)	tion	CO 10 Y	23d	d. Date of deliv	Approximate Interval Between Onset and Death Onset and Death
by Filysicialy Medical Examiner	disease or condition resulting in death)  Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent preg in the past 12 monttl 1 Yes 2 No	inant hs?	a. Due to (c. Due to (d. Due to (	or as a consequence of pregnant at time of dearwn	ence of):  Cy death 3   Ec th 5   O	CINOMA CCINOMA CCINOMA MFGIVA etopic pregnancy ther (specify)	tion	co respiratory	23d d tobacco use	d. Date of delive Month  contribute to the No 3 Prof	Approximate Interval Between Onset and Death  Very Day Year  the cause of death?  bably 4 InUnknow
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o be completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list condition and it is any, leading to immediause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent preg in the past 12 mont!  1 Yes 2 No 9 Unknown	inant hs?	a. Due to (c. Due to (d. Due to (	or as a consequence of pregnand at time of deal with but not result	ence of):  Cy  Jean 3 Ec  Lath 5 0	CINOMO CON  CON  A FARC  etopic pregnancy ther (specify)	Tion  Tion  26. Place of De	23e. Did 24a. Wt auti per 1 Yes	23d d tobacco use Yes 2 N as an lopsy formed? 2 N v one)	d. Date of delive Month  contribute to the second s	Approximate Interval Between Onset and Death Onset and Death Onset and Death?  Day Year Dably 4 Dunknow Opsy findings available on of cause of 2 No
to be completed by ruysiciarymedical examiner	disease or condition resulting in death)  Sequentially list condition if any, leading to immediate sease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  FFEMALE: 23b. Was decedent preg in the past 12 month 1 yes 2 No 9 Unknown  Part II. Other significant  25. Was case referred to examiner? 17. Manner of Death 1 27. Matural 5 2 Accident	inant hs?  conditions of medical	a. Due to (c. Due to (	or as a consequence of pregnancint 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient 2 Fetal cant at time of dealers with the patient at time of dealers	ence of):  Cy death 3 = Co ence of):  Cy death 5 = Co ence of):  R/Outpatient  8b. Time of Injury	ctopic pregnancy ther (specify)  prlying cause give  3 DOA Othe  28c. Injury Work 1 Y	a of	23e. Did 24a. We aut per 1 \( \sum \) Per ath (Check only) Home 5 \( \sum \) Re 28d. Describe	23d d tobacco use Yes 2 No as an lopsy formed? 2 El No y one) sidence 6 e e how injury on	d. Date of delive Month  contribute to the prior to concept the condeath?  1 Yes  Other (Special courred)	Approximate Interval Between Onset and Death Onset and Death Pearly Day Year the cause of death? bably 4 Dunknow oppy findings availably impletion of cause of 2 \square No
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regical Certification; To be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list condition any, leading to immediates. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  FFEMALE: 23b. Was decedent preg in the past 12 mont! 1	medical Pending investigation Could not be determined	a. Due to ( b. Due to ( c. Due to ( d. Due	or as a consequence of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of the	ence of):  Cy Jeance of):  Cy	ctopic pregnancy ther (specify)	26. Place of De r. 4 Nursing at res 2 No	23e. Did 24a. We autipel 1   Year   24a. We autipel 1   Year   24a. We autipel	d tobacco use  Yes 2 No  as an lopsy formed? 2 No  y one) sidence 6 e how injury or  (Street and Nown, State) e cause(s) and a date and pla	d. Date of delive Month  contribute to 1  No 3 Prol  24b. Were autor prior to condeath? 1 Yes  Other (Special Courred)	Approximate Interval Between Onset and Death Onset and Death Onset and Death?  Very Day Year the cause of death? bably 4 Dunknow oppy findings available of cause of 2 No.
Medical Certification; To Be Completed by Physician/Medical Examiner	disease or condition resulting in death)  Sequentially list condition any, leading to immediate sease. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  FFEMALE: 23b. Was decedent preg in the past 12 month 1 yes 2 No 9 Unknown  Part II. Other significant  25. Was case referred to examiner? 1 Yes 2 No 9 Unknown  Part II. Other significant  26. Was case referred to examiner? 1 Natural 5 Accident 3 Suicide 6 Homicide	medical  Pending investigation Could not be determined  Certifying Physical Exam  fi certifier  person who could be the country of the certifier  person who could be the certifier of the certif	a. Due to (c. Due to (	or as a consequence of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of pregnand the come of the	ence of):  Cy death 3 conce of):  Cy death 5 conce of):  R/Outpatient  8b. Time of Injury  ence of Injury  and/or invest  M/Outpatient  and/or invest  MOV	ctopic pregnancy ther (specify)	26. Place of De r. 4 Nursing at res 2 No	23e. Did 24a. We autipel 1   Year   24a. We autipel 1   Year   24a. We autipel	d tobacco use  Yes 2 No  as an lopsy formed? 2 No  y one) sidence 6 e how injury or  (Street and Nown, State) e cause(s) and a date and pla	d. Date of delive Month  contribute to the second seath?  1 Yes  Other (Special courred)  dumber or Rural dumber as second dumanner as second duma	Approximate Interval Between Onset and Death Onset and Death Onset and Death?  Very Day Year the cause of death? bably 4 Dunknow oppy findings available of cause of 2 No.

				tment of Health and Mental	Hygiene
	_			ificate of Death	Reg. No. 2004 3899
	Physici	an	1. Decedent's Name (First, Middle, Last)  Alex Melnick	2. Date of Month	Day Year
>	/Medic			Dec.  4b. City, Town, or Location of Death	2, 2004 3:30 p M
	Examin	er	Mariner Health of Silver Spring	Silver Spring	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8, Date of	Montgomery  f Birth D, Day, Year)  9. Birthplace (State or Foreign Country)
	Director		205-12-8520 X M 22 80 Yrs.		30, 1924 Pennsylvania
	and w.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	tion	10d. Inside City Limits
	Maryl -f sho	for	MD Montgomery Silver	Spring	1 _Yes 2 _ No
	r 28a	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	th wit	Funeral Director	2604 Plyers Mill Road	20902	United States
	er dea tems	uner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa Amed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.	as Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc	r No- 14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 3 Widowed 4 Divorced Year or Dates:	Yes 2√Ω No Specify:	Specify: White
Ş	be filed within 72 hours after death with the Maryland at Hygiene. All Hygiene. All Hygiene. All Hygiene. All Control than "natural", or items 23a or 28a-f show other than "natural" or recities a showly the Medical Evanities must be notified at	ted t	15. Decedent's Education 16a Deceden	nt's Usual Occupation	16b. Kind of Business/Industry
215	thin 7 e.	pie	(Specify only highest grade completed) (Give kin life. DO College (1-4or 5+)	nd of work done during most of working ONOT use retired)	Building
2	led wi ygien her th	Completed	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	upervisor	Construction
and	i be fil ntal H ad ott	Be	17. Father's Name (First, Middle, Last) Walter Melnick	18. Mother's Name (First, Mi	ddle, Maiden Sumame)
Maryland 21215-0036	should ind Men i marka umatic	은		Tillie Gela Address (Street and Number or Rural Route No	umbar City or Town State 7io Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan is Health and Mertal hygiene.  The mark and other than "natural", or thems 28a or 28a-1 show other treumatic event, the Medical Evantiner must be notified at				ver Spring, MD 20902
altimore,	es 1 a of Hea of Item r othe	1	20a. Method of Disposition 20b. Place of Disposition	ion (Name of Date tory or other place)	20c. Location - City or Town, State
Ē	Pages nent of the ant: If Ite			ce Crematory 12/9/04	Beltsville, MD
Balt	permit. Pages Department of Importent: If It any Injury or o			Name and Address of Facility	
	0 □ = e 0		23a. Part. Early to disease, or complications that caused the death. Do not enter to	33 Gist Avenue Silver	Spring MD 20010 ry arrest,
Ь	e -		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	the mode or dying, such as cardiac or respirato	ry arrest, — — — — proximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  a	lon Cancer	
	Examiner				
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury Cause (Disease or injury		
15	ecuted ind transi	Examiner	that initiated events		
8760,	be executed sician and burial-transit	icai Ex	Due to (or as a consequence of):		
687	physicate physics the l	0	d		
Вох	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
m m	death e atte	icia	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5 0	ctopic pregnancy hther (specify)	Month Day Year
P. O.	res that the de signed by the a be detached t	hys	9 Unknown		
Ś.	res th igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the under		Did tobacco use contribute to the cause of death?
Ö	w require been si should b	eted			Yes 2 No 3 Probably 4 XUnknown
Rec	The law cate has I page 2 s	Completed		a	Vas an utopsy erformed? 24b. Were autopsy findings available prior to completion of cause of death?
g		e Co	25. Was case referred to medical	1 ☐ Ye	es 2 No 1 Yes 2 No
Division of Vital Records,	2 0 5	To B	examiner?	3 DOA Other: 4 Nursing Home 5 ☐ F	4
0	ding Phy h. Atter thii funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury 28b. Time of Injury		be how injury occurred
SIO	Attendia death. ctor: Ai y the fu	catio	2 Accident investigation	M 1 Yes 2 No	
$\leq$	or Attency after death Director:	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  28e. Place of Injury - At home, farm, street, building, etc. (Specify)		on (Street and Number or Rural Route Number, Town, State)
_	To the Hospitel or Att within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 XCertifying Physicien: To the best of my knowledge, death or	coursed at the time, date and place, and due to	the cause(s) and manner as stated
	ne Ho 1 24 h ne Fur netely	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or investone)	stigation, in my opinion, death occurred at the tir	me, date and place, and due to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			When I legal und	D52261	December 6, 2004
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin		
	Sta	to	31 Date filed (Month Day Voar)	rton Drive Silver Spri	lng, MD 20902
	Registr	_	31. Date filed (Month, Day, Year) DEC 0 9 2004  32. Registrar's Signature	pouks	7

			For State Registrar				yland / D		nt of H	leaith a	and M	-	_	04	38992
	Physici	an	1. Decedent's Name (F						-			2. Date of De	eath Day	Year	3. Time of Death
7	/Medi Examir	cal	MYRTLE  4a. Facility Name (If no G • B • M • C •			number)		1	, Town, o	r Location	of Death	DECEM	4c. Coun	2004 by of Death	<i>Б</i> Рм Е
	Funeral Director		5. Social Security Numl 139-03-58	884	ех □ м 2 <b>/х</b> г	-	In yrs. last birth	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da 02/0	th ay, Year) 5/1912	Coun	lace (State or Foreign try) JERSEY
	show		Usual Residence of De 10a. State 10	b. County		1	0c. City, Town	or Location						10	0d. Inside City Limits
	the Maryla 28a-f shor	ctor	MD I	BALTIM	ORE		SPA	RKS							1 ☐ Yes 2 No
	€ º €	Funeral Director	10e. Street and Number 2206 TRA		חם				p Code 1152	)			10g. Citizen of	What Coun	try?
	heath w	eral	11. Marital Status	ACEIS	12. Was D	ecedent Ev	er in U.S.				igin? (Spe	ecify Yes or No Rican, etc.)	USA - 14. Ra	ce - Americ	an Indian.
	or Its	ρ	1 ☐ Never Married 3 ☐ Widowed 4 ☐	_	1 ☐ Ye	Forces? es 2 No Give r Dates:		If Yes, spo	_	Specify:		Rican, etc.)		ack, White, e	etc.
15-(	"ne"	lete	(Specify of	. Decedent's Econly highest gra	ducation ide complete	ed)	(	ecedent's Usi Give kind of w ife. DO NOT	ork done	during mos	t of worki	ng	16b. Kind of 8	Business/Ind	lustry
212	yene.	Completed	Elementary/Seconda 11YRS	ıry (0-12)	Colleg	e (1-4or 5+)		IMS D		•	Т		PENN.	RAIL	ROAD
	s 1 and 2 should be filed within if Health and Mental Hygiene. Ifem 27 is marked other then other treumatic event, the Mental Mental in the Mental in the Mental in its Me	Be	17. Father's Name (Firs										, Maiden Suma	тө)	
Maryland	should be nd Mental marked imatic ev	ဥ	HARRY GAU  19a. Informant's Name		Type Print)		19h A	Apilina Addres	s (Street			BUSH	er, City or Town	Stato Zin	Codol
	nd 2 salth an 27 ls		CAROLYN H			DAU							MD . 2		,
Baltimore,	pernit. Pages 1 a Department of Hes Importent: If item any injury or othe once.		20a. Method of Disposi 1 X Burial 2 □ C		Removal fro	om State	20b. Place of Control cemetery,	isposition (Na crematory or	me of other plac	:e)	C	ate	20c. Location	- City or Tov	wn, State
tim	artment ortent: I injury o		`4 ☐ Donation 5 ☐	Other (Specif	y)	JIII State	ARLING					0/200	PENNS	SAUKE	N,N.J.
Bal	Departing Depart		21. Signature of Funer	Service Licer	ISOO ALL	-)1		22. Name a	W.	JENI	KINS		NS CO.		
			23a. Part1. Enter the dishock, or heart fa	disease, or com	plications the	at caused th	e death. Do no	enter the mo	de of dyin	RK R g, such as	D MC cardiac c	NKTON r respiratory a	MD 2	1111.	Approximate Interval Between
	Physician	9 1	Immediate Cause (Final disease or condition		2 A	cute	myo	cardo	l u	fare	tin			3	Onset and Death
	/Medical Examiner		resulting in death)		Dug	to (or as a o	consequence of)		^ (	-				3	1
V.	mi.	e	Sequentially list conditi if any, leading to imme	lons, diate	b Due	to (or as a c	consequence of)	umor	u					-	dep
Vit	cuted od ransit	Examiner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injust that initiated events resulting in death) Last	ng ry	c.	mo	hica	ASIG						L	ray.
,092	ate be executed nysician and he burial-transit	ш	resulting in death) Last		ue	to (or as a c	consequence of)							0	
687	certificate be nding physicia use as the bur	edical			d										
B	death atter	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	nths?		e birth 2 ( egnant at tin	Fetal death	3 ☐Ectopic p 5 ☐ Other (s		1	11			ate of deliver	y Day Year
rds, P	w requires that the been signed by the should be detached	by	Part II. Other significan	nt conditions o	ontributing to	death but r	not resulting in th	ie underlying	cause give	en in Part I.			obacco use con Yes 2 4No		e cause of death?
Rec	elaw hasb ye 2 sl	Completed				_						24a. Was autor perfo	rmed?	prior to com death?	sy findings available pletion of cause of
	icien: Th certificate rector, pag	BeC	25. Was case referred examiner?								of Death	(Check only o		10103	-3/10/0/
of V	ding Physicien: h. After this certific funeral director,	2	1 Yes 2 No			te of Injury	2 ER/Outpa 28b. Tim		- W	4 🗆 140			dence 6 Oth		
	Jing After fune	ition		Pending investigation	(M	onth, Day Y	(ear) 200. Till	ry M	28c. Injury Work 1 □ `	γαι (? Yes <u>2</u> []	1	esa. Describe i	now injury occur	780	
		Medical Certification;		Could not be determined	286. Pla	ice of Injury	- At home, farm Specify)	, street, factor	y, office		2	8f. Location (	Street and Numi	ber or Rural	Route Number,
	urs afte ral Dir illed in	Cer	00.0.47								11				
	e Hospital 24 hours a e Funeral etely filled	dica	29a. Certifier 1 (Check only 2 one)	Medical Exan	uner: On the	the best of r basis of ex anner stated	ny knowledge, d tamination and/d d.	eath occurred r investigation	at the time , in my op	ne, date an pinion, deal	d place, a th occurre	nd due to the	cause(s) and m date and place,	anner as sta and due to t	ted. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title	of certifier				29	c. License	number			29d. Date signe	ed (Month, D	lay, Year)
			M		MI				DI	88Z	2		12/8	104	
	iO			HABERS	AT M	D. 1	11 MT.		EL 1	RD P	ARKT	ON, MD	21120	•	
	Sta Registr		31. Date filed (Month, D	C 0 9 2		Registrar's	Signature	4	-						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of l			iene 2004	38993
	Physic	ian	Decedent's Name (First, Middle, L.					2. Date of Deat Month	Dav Year	3. Time of Death
-	/Medi		MICHAEL V.	MCKAY				DECEMBE	\$ 6,2004	9:10 P M
4	Exami	ner	4a. Facility Name (If not institution, gr		•		or Location of Dea		4c. County of Deat	h
			UNIVERSITY OF  5. Social Security Number 6.	Maryuno 1 Sex 7. Age	(In yrs. last birthday			MRYWAR BIRTH	N/A	
	Funeral Director		-	1 □XM 2□ F 49		Months Days			Year) 9. Birti	nplace (State or Foreign untry) yland
	ס		Usual Residence of Decedent					12/30/1	JJ4 Mai	y Land
	arylan show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	8e-1	Funeral Director		George	Laure1					1 ☐ Yes 2 No
	with ti	Dir	10e. Street and Number			10f. Zip Code		11	ng. Citizen of What Co	untry?
	s 23	era	11510 Basswood Co	1	user in ILS 12	2070		>	USA	
40	ter de	Ë	11. Marital Status 1 □ Never Married 2 ★ Married	12. Was Decedent E Armed Forces?	verin U.S.	Was Decedent of I If Yes, specify Cub	hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	14. Race - Amer Black, White	
936	urs af	þ	3 Widowed 4 Divorced	1 ☐ Yes 2√ No If Yes, Give Year or Dates:		1 ☐ Yes X No	Specify:		Specify:	White
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show re Modical Exemirer must be notified at	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation			ndustry
21	thin 7	pie	(Specify only highest gi	College (1-4or 5+	life.	kind of work done DO NOT use retire	auring most of wo ad)	rking		
2	filed with Hygiene. Ither than	Co	12	2	Sa	les/Mark	0		Mohawk Con	npany
and	be fill	Be	17. Father's Name (First, Middle, Las	t)				me (First, Middle, N	faiden Sumame)	
3	2 should be find and Mental H. Is marked of raumatic ever	2	Edward McKay	(T D.: )			Godetta			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, I've Medical Exeminer must be notified at	0.1	19a. Informant's Name/Relationship						City or Town, State, Z.	
	s 1 and 2 of Health item 27 other tra		Christine McKay 20a. Method of Disposition	/ wile					Maryland Oc. Location - City or 1	
altimore,	e = 5		1 ☐ Burial 2 ☐ Cremation 3 [		20b. Place of Dispersion of Competery, cre					
Ē	그 는 은 글		' 4 □ Donation 5 □ Other (Special Signature 1 Funeral Service Lice		Balt/Was	h Cremato	ory   12/	8/2004 J	Laurel, Mar eral Home,	yland
Ba	Depar Impo	(	A envia An	Dart					erai nome, irel, Maryl	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused to						Approximate
	Pnysician		Immediate Cause (Final	. 1						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		consequence of):	y concer				4 years
	Examiner		Conventially list conditions	b						
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
90,	ate be executed hysician and the burial-transit	<u> </u>	resulting in death, East	Due to (or as a	consequence of):					
8760	ate hy:	dicai		d		··-				
9 X	The law requires that the death certific that been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of	foregnancy					
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnanc	у		23d. Date of deliv Month	ery Day Year
o.	at the de by the a	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	5. 454 52	_ caron (specify) _				
<b>T</b>	s that	by Pł	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	quires in sign uld be							1 × Yes	2 □ No 3 □ Pro	bably 4 Unknown
00	aw requir as been si 2 should	Completed						24a. Was an		opsy findings available
R	The lav	E O						autopsy	ed? prior to co	empletion of cause of
of Vital Records,		0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ath (Check only one		2EJ NO
_ \	dii dii	To B	examiner? 1 Yes 2 No	Hospital: Inpatient	2 ER/Outpatier	nt 3 DQA Oth			nce 6 Other (Speci	fy)
n 0	ding Ph h. After th funeral		27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	Year) 28b. Time o	f 28c. Injui Woo	ry at rk?	28d. Describe how		
Sio	Attending r death. sctor: After by the funer	cati	2 Accident investigation	n			Yes 2□No			
Division	l or Attendation after deati	Certification;	3 Suicide 6 Could not to determined	28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	Hospitel or 14 hours afte Funeral Dire tely filled in b		200 Comilios 1 Promition B							
	Hos 24 hc Fun stely	edicai	29a. Certifier 1 Certifying Pl (Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of e and manner state	xamination and/or in	n occurred at the till vestigation, in my o	me, date and place opinion, death occu	red at the time, dat	ise(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the Hospitel or Al within 24 hours after of To the Funeral Direc completely filled in by	Mec	29b. Signature and title of certifier	and mailler state		29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
	F ≤ F ö		> ( with	کم		21	6561		PECEMBER 6	
	(1)		30. Name and address of person who	completed cause of dea	ith (Item 23a) (Tyne	Print)				,
	\"		V MAII	D LINA, Z	2 S. Green	G ST., BA	LTMORET	MD 2120	\	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	boards				
	Registr	ar	DEC 0 9 2004	De ve	P A	parks				

State of Maryland / Department of Health and Mental Hygien 2 1 14 38994 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Carole Ruth Miles December 5, 2004 8:25P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1015 8th Street Laurel Prince George 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🛱 F Months Days Hours Director 69 314-32-6080 11/14/1935 Indiana Usual Residence of Decedent death with the Maryland r 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2□No MD Prince George Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral', or Itams 23s or 1015 8th Street 20707 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Ita Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 □ Divorced Specify: Completed other traumatic evant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Walter S. McCoy 2 Garnett Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie C. McLaughlin/Daughter 1013 8th Street, Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 12/11/2004 Brentwood, Maryland nure of Fineral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Endometrial Carcinoma recurrent 10 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical the ası IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate ! 1 ☐ Yes 2**X**□ No 1 ☐ Yes 2X No To the Hospital or Attanding Phyaician: within 24 hours after death. To tha Funaral Diractor: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 TNo Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 12/8/2004 30. Man e and address of person who completed cause of death (Item 23a) (Type, Print) Burrell, 2730 University Blvd. #400, Wheaton, MD 10902 Linda M. MD31. Date filed (Month, Day, Year) State 32 Registrar's Signature DEC 0 9 2004 Registrar Oaks

			For State Registrar	State of M	arylan		artment of H				ene g. N2 0	04	389	95
	Physici /Medi		1. Decedent's Name (First, Middle, L Huldah McNind							2. Date of Death Month Novembe		Year 2004	3. Time of 4:05	
*	Examir		4a. Facility Name (If not institution, g Fairland Nurs	sing Home		10-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	4b. City, Town, or Silver		.ng		4c. Count	y of Death	-	
	Funeral Director		579-22-0225 Usual Residence of Decedent	.Sex 7. Ag	85	last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, July 10,	1919	9. Birthp Court Non	olace (State on htry) th Can	r Foreign rolina
	ne Marylan 8a-f show	Director	MD 10a. State 10b. County Montgom	ery	10c. City	y, Town or Lo Silv	er Spring	5	1				0d. Inside Ci 1 ☐ Yes	
	th with th	al Dire	10e. Street and Number 2101 Fairland R	oad			10f. Zip Code	2090	)4	10	g. Citizen of	What Coun	itry?	
036	urs after dea al', or Items txeminer m	by Funeral	11. Marital Status  1 ⅓ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2X If Yes, Give Year or Dates:	2		Was Decedent of Hi f Yes, specify Cuba	ispanic Orion, Mexican  Specify:	gin? (Spe n, Puerto f	cify Yes or No- Rican, etc.)	Bla	ce-Americ ck, White, fy: Whi	etc.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Exartrar must be routhed an once.	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) unk	Education grade completed)  College (1-4or to the control of the c	5+)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired art	luring most )	t of workir	ng 1	6b. Kind of B	usiness/Ind	iustry	unk
land 2	uld be filed vental Hygie vental Hygie riked other i	To Be Co	17. Father's Name (First, Middle, Las Frank McN	st)			arc		r's Name	(First, Middle, Ma	aiden Sumar	ne)		unk
Mary	alth and A		19a. Informant's Name/Relationship  John Hunter/nepl				g Address (Street a					State, Zip		
Baltimore,	Pages 1 ament of He ent: If item ury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 1 □ Donation 5 ☑ Other (Spec	□Removal from State	C	lace of Dispo	sition (Name of natory or other place				oc. Location			
Ball	Depart Depart Import any in		process.	wades Dir	10	Ba	Ate Anato 1timore,	MD	21201			ore S	treet	
	Physician		23a. Pant. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	ly one cause on each li	<sup>ne.</sup> ic en	cephal	opathy	g, such as	cardiac or	r respiratory arres	it,		Approximate Interval Bety Onset and D	ween
i	/Medical Examiner	her	Sequentially list conditions, if any, leading to immediate cases. Enter Underlying Cause (Disease or injury	b. Due to (or as	irato	ry fai	lure							
8760,	e be executed rsician and e burial-transit	dical Examiner	Causa (Disease or Injury that initiated events resulting in death) Last	c. aspi		n pneu	monia							
O. Box 6	the death certificate be executed by the attending physician and ached for use as the burial-transit	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)					te of deliver	-	'ear
rds, P	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions malnutritio		ut not resu	ulting in the un	derlying cause give	en in Part I.		23e. Did toba 1 □ Yes	cco use cont	ribute to the		eath? Inknown
al Record	The ate h page	Completed								24a. Was an autopsy performe	d?	prior to com death?	osy findings a apletion of ca 2 \( \square\) No	ivailable iuse of
ion of Vital	Phys r this ral dir	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigati		iry	ER/Outpatient 28b. Time of Injury	28c. Injury Work	E 4 X Vur	rsing Hom	(Check only one)  ie 5  Resident  8d. Describe how			)	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification	3 Suicide 6 Could not determine	d 289. Place of Injury	c. (Specity					8f. Location (Stree City or Town, 1	State)			70°,
	To the Hospitel or A within 24 hours after To the Funerel Direction properties of the Funerel Direction by the Funerel Di	Medical	one)	Physician: To the best eminer: On the basis of and manner sta	i examinat	wledge, death ion and/or inv	estigation, in my op	inion, death	d place, ar h occurred	d at the time, date	and place,	and due to	the cause(s)	
•	To To		29b. Signature and title of certifier	Please		w	29c. License			290	Date signed		Day, Year) , 2004	
			30, Name and address of person who	& Seg.	al	23a) (Type, F	Print	The	rsi	ng Ho		Selve	Ser	· ·
• •	Sta Registr	_	31. Date filed (Month, Day, Year) DEC 0 8 2004	32. Registra	ars Signat	posts	•			9			/	5

State of Maryland / Department of Health and Mental Hygien 1- State Registrar AMEND ITEM #10e PER FH CETSICATE MODE JH Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTAV DEC. 6 2004 MOSCUNA 1:20 P M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death assisted Living Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday). **Funeral**  Birthplace (State or Foreign Country) Days Hours Director 212-37-6362 86 06/04/1918 ROMANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Director MD HOWARD 1 Yes 2 No COLUMBIA 11724 Number 10f. Zip Code 10g. Citizen of What Country? 117224 BRIGHT PASSAGE Itama 23a 21044 Funeral **ISRAEL** Was Decedent Ever in U.S. Armed Forces? 1 Yes 2M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or itan any injury or othar traumatic avant, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No WHITE Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) MECHANICAL ENGINEER ENGINEERING 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ISAC 2 MOSCUNA OTILIA **AUSLENDER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICORICA P. HAGI-DUVAN/DAUGHTER 11724 BRIGHT PASSAGE COLUMBIA, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 12/08/2004 REISTERSTOWN, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia disease or condition resulting in death) years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ame mia Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Momie 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【No 24a. Was an After this certificate has autopsy 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? akkyted Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Certification: To 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred or Attanding s after dea. ral Diractor: Afte 5 Pending 2 Accident investigation 1 Yes 2 No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ridge mD21044 10780 Hickory 31. Date filed (Month, Day, Year) 32. Registra s Signature State DEC 09 2004 Registrar

<b>Physici</b>	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		Year	3. Time of Death
/Medic		SONDRA			PARSO		DEC.		200 <sup>Year</sup>	10:45 A
Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or BALT IMOI				Inty of Death	
uneral		3303 TIMBERFIELD  5. Social Security Number 6. Se		yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt			place (State or Forei
rector		Usual Residence of Decedent	<del>X</del> M <del>XX</del>	72 Yrs.	Months Days	Hours Min.	8. Date of Birt DEC. 26	(1931		עויו
a-f shov tified at	ctor	, , , , , , , , , , , , , , , , , , , ,	LTIMORE	BALTI						10d. Inside City Limi 1 ☐ Yes 2 💢 N
at be no	Funeral Director	10e. Street and Number 3303 TIMBERFIELD	LANE		10f. Zip Code	21208		10g. Citizen	of What Cou	ntry? USA
imposed in the first production of the major	by Funer	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2 🕅 No	spanic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		Race - Ameri Black, White, scify:	
e Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	16a. Dece (Give life. OWNER	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of work	sing		f Business/Ir	
imatic event, the Mi	To Be Co	17. Father's Name (First, Middle, Last) PHILLIP		SHAPI		18. Mother's Nam	e (First, Middle,		name)	INBERG
r treuma		19a. Informant's Name/Relationship (7) MICHAEL PARSON /			ng Address (Street a			-		Code)
ry or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hellicvas Itolii State		osition (Name of matory or other place OM MEMORI	1	6/2004		n - City or T	own, State
Importer any Injui once.		21. Signature of Euneral Service Licens		2:	2. Name and Address	s of Facility SO	L LEVINS	SON &	BROS.,	INC.
sician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	0.	death. Do not en						Approximate Interval Between Onset and Death
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I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a)con	ardial	infarch	700				1 Month 6 weeks
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igned by the attending prysician and be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ i 4 □ Pregnant at time 9 □ Unknown	Fetal déath 3	Ectopic pregnancy Other (specify)				Date of delive	ery Day Year
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page 2 should	omplet	insulin depe	indent dia	beles j	nellitus		24a. Was a autops perfor	sy	prior to co death?	psy findings available mpletion of cause of
is certificate director, pag	BeC	25. Was eferred to medical				26. Place of Deatl		/ -		
After this funeral di	P	1 Yes No  27. Manner of Death 1 Natura! 5 Pending 2 Accident investigation	Hospital: 1 Inpatient :  28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Injury Work	at	me 5 eside 28d. Describe he	ence 6 Co		y)
To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	eet, factory, office		28f. Location (Si City or Town		nber or Rura	l Route Number,
letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	rsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the time vestigation, in my opi	e, date and place, nion, death occurr	and due to the cred at the time, d	ause(s) and ate and plac	manner as si e, and due to	tated. the cause(s)
는 년	Me	29b. Signature and title of certifier		MY	29c. License	number	2	9d. Date sign	ned (Month,	Day, Year)
0 00		12	/		1 1/ 1/	/ / 1 // /		1		mm / /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RegistrarAMEND ITEM #16b&19a PER FIT 6838 PER 15 109/04 Reg. No. 1. Decedent's Name (First, Middle, Last, DEC. Day 6 **Physician** 2004 9:05 Ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SPRINGHOUSE ASSISTED LIVING BALTIMORE PIKESVILLE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 08/25/1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F **Funeral** MD 89 Director 215-10-6680 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10h County 10a State 28a-f show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2√ No Director MD BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ŏ 8911 REISTERSTOWN ROAD 21208 U.S.A. Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No 0 Baltimore, Maryland 21215-0036 Specify: 3 Nidowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry HARDWARE al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNER HAREWARE STORE 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be and Mental I PAUL **GARBUS** LILLIE MORRIS ဂ္ 19b. Mailing Address (Street and Number of Burn Haute Number City of Town, State, Zip Code)
1571 BROOKSIDE ROAD MOUNTIANSIDE, N.J. 07092 19a. Informant's Name/Relationship (Type, Print) if itam 27 1571 BROOKSIDE ROAD JUDI SILVERMAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of important: if any injury or 12/08/2004 BETH TFILOH CONG. WOODLAWN, MD \*4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Tuneral Service Licensee lote 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEROSCHEROTIL CEREBRO VASCULA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nding physician and use as the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Oate of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed TENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate 2 No Yes ASSISTED Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Ther (Specify) LIVING 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural

Division of Vital To the Hospital or Attending Physician: After death. Director: 24 hours a within 2 To the

Certification:

cai

2 Accident

3 🗌 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

State Registrar 29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date-signed (Month, Day, Year,

28l. Location (Street and Number or Rural Route Number, City or Town, State)

ol death (Item 23a) (Type, 30. Name and address of person who completed cause

7220

and manner stated

ASNEEN

31. Date filed (Month, Day, Year) 32. Registrar's Signature

DEC 0 9 2004

6 Could not be

determined



28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registras Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea **Physician** 515 A M Queer JEAN 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gambrills Mitchell Anne. Anunde Queen Ruad If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🛣 F MD 215.40.21650 Director 03 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a, State Items 23a or 28a-f show incr must be notified at MD Anne 1 ☐ Yes 2 1 No **Funeral Director** Anundel Gambrills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2404 Queen Mitchell Road 2105 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
Int: If itam 27 is merked other than Contractura SECRETARY 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDGAR A. SEWELL THELMA DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2404 Queen Andrew C. Queen Rd. Gambrills MD 21054 of Health of Itam 27 I Husbana Mitchell 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department o Important: If any injury or once. Hanover, MD 12.11.04 ST, REST CEMETERY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funcial Service Licen 22, Name and Address of Facility
Vaughn C. Greene Funeral Services
SIST Baltimore National Pike Balti Baltimore MD aus 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE nse. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month ō in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the a detached i 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 🗌 Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 22/No 212 No 1 Yes 1 🗌 Yes or Attanding Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient P 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation s after dea...ral Director: Afr 1 🗌 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funaral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

DHMH 17 Rev 1/2001

DEC 0 9 2004

30. Name and address

550

31. Date filed (Month, Day, Year)

32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

lucy

DHMH 17 Rev 1/2001

State

Registrar

2004

DECEMBER 7,

32. Pegistrar's Signature

**DEC 0 9** 2004